MARYLAND HEALTH CARE COMMISSION

REQUIRED UNDER SECTIONS 15-1501 AND 15-1502 OF THE INSURANCE ARTICLE

Mandated Health Insurance Services Evaluation

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Report Prepared by
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Executive Summary

In 1998, pursuant to Sections 15-1501 and 15-1502 of the Insurance Article, the Maryland Health Care Access and Cost Commission (HCACC), predecessor of the Maryland Health Care Commission (MHCC), was required to:

- Conduct an initial evaluation of the cost of existing mandated benefits
- Recommend the appropriate percentage of the average annual wage in Maryland that the total cost of mandated health insurance services may not exceed
- Assess the financial, social, and medical impact of proposed mandates.

Mandated benefits are defined as those mandates for health services contained in Title 15, Subtitle 8 of the Insurance Article.

The HCACC hired Mercer Human Resource Consulting (Mercer) to prepare a report to the General Assembly in 1998 to address these issues. Using the recommendations in the Mercer report, in 1999 the General Assembly passed SB625 "Mandated Health Insurance Services – Cost Determination" to require the Commission to continue evaluating the existing and proposed mandates annually and to assess the fiscal impact of current mandates in consideration for a state-mandated affordability cap of 2.2% of Maryland's average annual wage. Since 1999, the MHCC has contracted with Mercer to perform this analysis annually.

The following report analyzes the cost of existing mandates, including those passed in the 2002 session of the legislature, as to the affordability cap, and it evaluates the financial, social, and medical impact of mandates proposed for the 2003 legislative session.

We used the following resources in the assessment:

- Mercer-conducted surveys of health plans as to current practices
- Mercer-conducted surveys of collective bargaining agents and health coalitions on their level of interest in negotiating for the benefits in the proposed mandates
- Fiscal notes on proposed mandates prepared by the Department of Legislative Services
- Mercer databases on indemnity and managed care plans
- Surveys of self-insured groups on voluntary coverage of mandates conducted by Commission staff
- Mandate-specific research by Mercer's medical consultants.

Financial Analysis of Current Mandates

Subtitle 8 of Title 15 of Maryland's insurance law currently has 40 "required health insurance benefits for services" (Sections 15-801 through 15-840) that insured health plans must include. This report analyzes the cost of these mandates for four types of contracts:

Executive Summary

- Group insurance plans
- Individual insurance plans
- Comprehensive Standard Health Benefit Plan for small groups
- Maryland State Employee Benefit Plan.

The financial cost of mandated health insurance benefits could be defined as the full cost of the benefit, or it could be defined as the marginal cost of the mandate, where the marginal cost equals the full cost of the benefit minus the value of the services that would be covered in the absence of the mandate.

On a full-cost basis, the total cost for all the current mandates is about 15% of premium. As a percentage of Maryland's average wage, assuming the same average wage for all types of insurance contracts, the full cost ranges from 1.8% to 2.9% and averages just under 2.2%.

On a marginal cost basis, for all the current mandates, the average cost is about 4.2% of premium across all insurance contracts. As a percentage of Maryland's average wage, the marginal cost ranges from 0.4% to 0.8% and averages about 0.6%.

Compared to the costs specified in the Mandated Health Insurance Services Evaluation report prepared by Mercer in 2001, the cost of the mandates as a percentage of wages has increased slightly. This is because the cost of health care has been increasing faster than the average wage, and the legislature passed two bills that expanded the mandates:

- HB 692 expanded section 15-835, which mandates coverage of habilitative services for children
- HB 896 added section 15-840, which mandates coverage of residential crisis services.

Financial, Social, and Medical Impact of Proposed and New Mandates

The following proposals were reviewed for their potential financial, medical, and social impact:

- HB 738: "Health Insurance Carriers – In Vitro Fertilization – Conditions for Provision of Benefits"
- HB 1129: "Health Insurance – Coverage for Vaccinations Against Meningococcal Disease"
- SB 370: "Health Insurance Carriers – Standing Referrals to Specialists"
- Mental Illness Coverage Period for Children.

This portion of the report contains background information for legislators. It does not recommend which proposals should be passed. Determining the relative importance of the financial, social, and medical impact of proposed mandates is the prerogative of the legislature.

Affordability Cap on Mandates

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The full cost of current mandates is just under 2.2% of Maryland's average annual wage, which is barely below the statutory affordability cap of 2.2% of average wages. Under legislation passed in 1999, if the full cost of mandates meets or exceeds the affordability cap, a moratorium must be put on passage of new mandates and a full evaluation of the fiscal, social, and medical impact of all mandates must be given to the General Assembly in September of the following year. Proposals to safeguard life and health could still be passed on an emergency basis.

The fiscal impact of current mandates is below the cap; therefore, no action is necessary this year. Because the rate of increase in health care costs continues to exceed the rate of increase in wages, we expect the cost of mandates to exceed the ceiling next year.

Mandates make up about 15% of the full cost of health insurance premium and about 4.2% of the marginal cost. These mandates were adopted because they are considered essential areas of health care. Neighboring states in the Mid-Atlantic have also adopted similar mandates. The estimated cost for a full evaluation of all mandates could exceed $400,000 and would not address the other 85% of health care costs.

Given the State's current budget deficit and the rising cost of health care, a more prudent use of funds should be considered. The Commission should consider a request to the General Assembly to modify the current statutory requirement to review all mandated benefits if the cost exceeds 2.2% of Maryland's average annual wage.

The current statutory requirement to assess each existing mandate as to its fiscal, medical, and social impact is impractical and the resulting report would not lead to a significant reduction in mandates (or a decrease in premium) as was intended. It is difficult to repeal mandates piecemeal.

The Commission should propose a less costly but more encompassing study that would cover the full cost of health care premiums including carriers' administrative expenses. The study would examine the types of health care benefits covered, areas where Maryland's mandates exceed the mandates in other states, and the cost of administering these health plans. From this information, the MHCC could develop decision-making criteria for reducing mandates and addressing rising costs.

The current statutory study is required to begin after the 2.2% cap is actually exceeded. Assuming this threshold would be reached in the report issued on December 31, 2003, the study would occur in 2004. However, the actual work on the proposed alternative study could begin prior to that date.

Introduction

This report contains four sections. The first section addresses the financial cost of current mandates in relation to the statutory income affordability cap. The next section addresses the financial, social, and medical impact of each of the new or proposed mandates. The third section addresses the affordability cap on mandates. The last section contains a bibliography of sources referenced in this report.

This report uses various sources of information. As required by statute, the report refers to a survey of health plans and a survey of collective bargaining agents. Mercer surveyed 10 prominent health plans in the Maryland market; four of them participate in the Maryland small-group market. The health plans were surveyed on their coverage practices in both the small-group and large-group markets in Maryland. The surveys produced data for an overview of practices and coverage in the Maryland marketplace.

Mercer also conducted a telephone survey of Maryland collective bargaining agents. The sample included groups such as the AFL/CIO, Laborers International, AFSCME, Building and Construction Trades, and United Food and Commercial Workers. The survey assessed their level of interest in negotiating for coverage and their support for or opposition to the proposed mandates. While they consider some mandates socially desirable, monetary constraints may affect their willingness to negotiate for the coverage.

We also surveyed the Maryland Department of Budget and Management, Office of Personnel Services and Benefits, on its compliance with current and proposed mandates.

Each of the bills had accompanying Fiscal Notes with additional information on the cost impact.

Mercer's analysis incorporates data from our proprietary databases, which include financial information on indemnity and managed care plans. These databases were developed by purchasing data from other sources and through several comprehensive surveys. We update the databases regularly.

When analyzing existing mandates, we incorporated the results of a 1999 survey of self-insured employers conducted by Commission staff. The Commission survey results covered 29 self-insured groups that were exempt from the mandates. The survey results show the portion of groups that cover the mandates voluntarily. Another major resource for this report was the Internet. Through searches on the Internet, we collected published articles and information on the proposed mandates.

This report includes information from several sources to provide more than one perspective on each proposed mandate. Mercer's intent is to be unbiased. At times, as a result, the report contains conflicting information. Although we included only sources that we consider credible, we do not state that one source is more credible than another. The reader is advised to weigh the evidence.

Introduction

The Mercer staff on this report included medical, actuarial, and research specialists. The medical staff coordinated the study of the medical impact and assisted on research of the financial and social impact of the mandates. The actuarial staff coordinated the analysis of the financial impact.

Financial Analysis of Current Mandates

The financial cost of mandated health insurance benefits could be defined either as the full cost of the benefit or as the marginal or additional cost of the mandate. The marginal cost equals the full cost of the benefit minus the value of the services that would be covered in the absence of the mandate. For example, the full cost for requiring coverage of hospitalization for maternity equals the assumed number of maternity cases times the hospital cost per case. The vast majority of contracts would include coverage of maternity cases without the mandate; therefore, the marginal cost equals the assumed number of cases that would not be covered without the mandate times the hospital cost per case. This report shows estimates for both the full cost and the marginal cost.

Exhibit 1 summarizes the cost of the "required health insurance benefits for services." The costs are summarized for four types of contracts:

- Group insurance plans
- Individual insurance plans
- Comprehensive Standard Health Benefit Plan for small groups
- Maryland State Employee Benefit Plan.

There are two types of "required health insurance benefits for services": mandated coverage of services and mandated offering of riders or other policies. Because the mandated offering of benefits does not require a benefit to be covered under the standard policy, we show the cost as $0 for mandated offerings.

Based on data from the *State Health Care Expenditures: Experience from 2000*, which was produced by the MHCC, the Maryland average per-capita expenditure for covered services, including administration, for 1999 and 2000 was:

	Total Spending Including Administration Cost		
	1999	**2000**	**Percentage Change**
Insured and self-funded plans	$1,748	$1,996	14.2%
HMOs	$1,967	$1,985	0.9%

Using surveys of premium rates and carrier rating trends in Maryland, we estimate that per-capita costs in 2001 were 14.9% higher than in 2000. We estimate that on average there are between 2.1 and 2.2 members per contract. With 2.2 members per contract, 14.9% annual trend, and the 2000 spending rates from the table above, the estimated cost per contract for 2001 is:

Financial Analysis of Current Mandates

	Enrollment Weight	Per-Contract Cost
Insured and self-funded plans	64.8%	$5,045
HMOs	35.2%	$5,018
Composite	100.0%	$5,036

The Mercer/Foster Higgins Survey of Employer-Sponsored Health Plans showed an average cost per contract of $6,187 for 2001. The focus of this survey is medium and large employers. Averaging this with the composite rate of $5,036 from the MHCC data, we estimate an average rate of $5,611 per contract for group policies in 2001. Also, we estimate that the average individual policy cost is about 40% or $7,837 per contract. The average cost per contract, including benefit riders and estimated patient liabilities (deductible, copays, and coinsurance), for the small group market was $4,898 in 2001. Excluding patient liabilities, the average small group premium was $4,391 per contract. Overall, across all types of policies, we estimate that the average spending per contract was $5,604 in 2001. Exhibit 1 shows the estimated 2001 cost for current mandates and the:

- Relative cost factors by type of contract
- Cost of each mandated benefit under a group contract
- Cost of the mandates as a percentage of the premium cost and as a percentage of the average Maryland wage.

The total costs by policy type are shown at the bottom of the page, adjusted to the cost level for the type of contract.

When expressing the cost of the mandates as a percentage of the average annual wage, we did not segregate the wage by type of delivery system; therefore, we used the same wage base for all types of contracts. The average annual wage in 2001 was $38,329, according to statistics from the Maryland Department of Labor, Licensing and Regulation (DLLR). This is 5.1% higher than the 2000 Maryland average annual wage of $36,452.

On a full-cost basis, the total cost for all the current mandates is about 15% of premium. As a percentage of Maryland's average wage, assuming the same average wage for all types of insurance contracts, the full cost ranges from 1.8% to 2.9% and averages just under 2.2%.

On a marginal cost basis, for all the current mandates, the cost averages about 4.2% of premium across all insurance contracts. As a percentage of Maryland's average annual wage, the marginal cost ranges from 0.4% to 0.9% and averages about 0.6%.

Financial Analysis of Current Mandates

The most costly mandates are:

- Mental health and substance abuse treatment
- Maternity care.

Compared to data in our 2001 report to the MHCC, the cost of the mandates as a percentage of wages increased slightly, from 2.1% to just under 2.2% for the full cost and remained at 0.6% for the marginal cost. The cost as a percentage of premium has increased from 14% to 15% for the full cost and from 4.0% to 4.2% for the marginal cost. The cost of most mandates, as a percentage of wages, has increased because the cost of health care has increased faster than wages and because two new bills expanded the mandates:

- HB 692 expanded section 15-835, which mandates coverage of habilitative services for children
- HB 896 added section 15-840, which mandates coverage of residential crisis services.

Addition of the new mandates also caused the cost of mandates as a percentage of premium to increase.

A financial analysis of the proposed mandates is presented in the next section. For a summary, see Exhibit 2.

Financial, Social, and Medical Impact of Proposed Mandates

HB738: "Health Insurance – In Vitro Fertilization – Conditions for Provision of Benefits"

Currently, under Section 15-810 of the Maryland Insurance Law, benefits for all outpatient expenses arising from in vitro fertilization (IVF) procedures must be covered to the same extent as for other pregnancy-related procedures if the patient's oocytes are fertilized with her husband's sperm. Under this bill, if IVF, through fertilization of the patient's oocytes with her spouse's sperm, is impracticable because the spouse is infertile, donor sperm may be used unless the spouse's infertility is due to elective sterilization or the unsuccessful reversal of elective sterilization.

The report on this proposed mandate includes information from several sources to provide more than one perspective. As a result, it contains some conflicting information. Mercer's intent is to be unbiased. While we included only sources we consider credible, we do not state that a given source is more credible than another source. The reader is advised to weigh the evidence.

A discussion of the financial, social, and medical impact of this bill follows.

Financial

As explained in the social section on the next page, 0.3% of couples seek IVF treatment annually. They may need more than one IVF cycle. We estimate 1.5 cycles are attempted on average before achieving pregnancy or stopping the attempts. About 50% of the cases are due in part or entirely to male factors. Approximately 50% of covered employees also cover a spouse. Given these assumptions, we expect one IVF cycle per 1,000 covered employees.

The hardest variable to evaluate is the number of male factor infertility cases where fertilization of the patient's oocytes with her spouse's sperm is impracticable. This bill does not define impracticable and does not say who makes the determination. Because of progress in treatment, some types of cases that once would have been impracticable are now practicable. We assume that the couple will desire fertilization with the husband's sperm if at all possible. Using the information in the medical and social impact section, we estimate that up to 10% of male factor infertility cases will require the use of donor sperm but only one-fifth of these will require IVF. The cost per IVF cycle is about $8,000 to $9,000.

We assume the other four-fifths of the cases using donor sperm will require intrauterine insemination (IUI), possibly combined with ovulatory stimulation. The cost per cycle for IUI is thousands of dollars less than IVF, but the success rate is significantly lower; therefore we assume the same cost per case.

Overall, up to 5% of infertility cases or almost five cases per 100,000 covered employees will require the use of donor sperm for IVF or IUI.

Financial, Social, and Medical Impact of Proposed Mandates

This benefit expansion is expected to increase costs about $0.50 per contract annually. In our survey of carriers, all excluded coverage when donor sperm was used; therefore, the marginal cost equals the full cost. Also, they all stated that the premium impact for this benefit expansion would be minimal. The projected full cost and marginal cost are summarized in the table below.

	Full Cost	Marginal Cost
Estimated cost of mandated benefits as a percentage of average cost per group policy	0.0%	0.0%
Estimated cost as a percentage of average wage	0.00%	0.00%
Estimated annual per-employee cost of mandated benefits for group policies	$0.50	$0.50

Social

In this section, we address the following:

- The extent to which the service is generally used by a significant portion of the population;
- The extent to which lack of coverage causes a plan member to avoid necessary health care treatments;
- The extent to which lack of coverage results in unreasonable financial hardship;
- The level of public demand for the service;
- The level of interest of collective bargaining agents in negotiating privately for inclusion of this coverage in group contracts; and
- The extent to which the mandated health insurance service is covered by self-funded employers in the state who employ at least 500 employees.

Financial, Social, and Medical Impact of Proposed Mandates

Infertility is the inability of a sexually active couple who want a child to achieve pregnancy in one year. About 8% to 10% of couples are infertile. Approximately 20% of these couples seek infertility treatment. Of those who seek treatment, about 40% do so primarily because of female factors, 40% for male factors, and 20% for a combination of male and female factors. About 85% to 90% of couples are treated with conventional therapies such as prescription drugs or surgical repair of reproductive organs. About 3% of infertile couples (or 0.3% of all couples) seek treatment with IVF each year.

The cost per IVF cycle is about $8,000 to $9,000. Without coverage, treatment could be cost-prohibitive. Carriers we surveyed all follow the current mandate and exclude coverage of IVF when donor sperm is used. If the treating physician determines that male factors make it impracticable to use the husband's sperm, the treating physician would not recommend IVF with the husband's sperm, but may recommend the use of donor sperm. This bill does not define impracticable or who determines if it is impracticable. With progress in infertility treatment, cases that were once impracticable are now considered practicable. This bill leaves room for debate on when coverage for IVF with donor sperm should be excluded.

The current mandate on coverage of IVF requires health insurance plans and HMOs to cover the outpatient costs of IVF as long as the patient meets the following requirements:

- Her eggs must be fertilized with her spouse's sperm.
- She is unable to get pregnant through less expensive treatment covered by the policy or contract.
- She and her spouse have had a history of infertility for at least two years, or the infertility is associated with any of the following conditions:
  - Endometriosis
  - Fetal exposure to diethylstilbestrol, commonly known as DES
  - Blockage of, or surgical removal of, one or both fallopian tubes
  - Abnormal male factors, including oligospermia
- The IVF procedures are performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for IVF clinics or to the American Fertility Society minimal standards for IVF programs.

Coverage may be limited to three IVF attempts per live birth and a maximum lifetime benefit of $100,000. The mandate does not apply to groups with 50 or fewer employees.

The normal process of fertilization starts with the sperm breaking through cervical mucous, then traveling up the length of the uterus and entering the fallopian tube. In the fallopian tube, the sperm must meet an egg, penetrate the egg's protective coating and inner membrane, and fertilize the egg. With male factor infertility, one or more of these steps are impaired. Male factor infertility can be caused by:

- Low sperm counts
- Poor motility or movement of the sperm
- Poor sperm quality
- Inability of sperm to penetrate the egg.

We will classify male factor infertility into four types of factors and discuss each:

- Structural abnormalities
- Sperm production disorders
- Ejaculation disturbances
- Immunologic disorders.

Structural abnormalities

Structural abnormalities partially or totally block the flow of sperm and/or seminal fluid. It could be caused by an infection of the urogenital tract, surgery to correct other abnormalities in the reproductive system, or congenital causes such as:

- Congenital absence of the vas deferens (CAVD) – Testicular function may be normal, but the tube that leads from the testicle has been absent from birth; therefore, sperm is not contributed to the ejaculation.

- Cryptorchidism or undescended testes – This would be the absence of one or both testes. If the testes do not descend by the child's first birthday, the condition is usually treated surgically. If left untreated, the testes can shrivel and lead to infertility and an increased risk of testicular cancer.

- Hypospadias – If the urethral opening is not in its normal position at the tip of the penis, fertility could be affected.

- Kallmann's syndrome – This is a lack of the hormone GnRH, essential for sperm production, caused by failure of the hypothalamus.

- Kleinfelter's syndrome – This is a poorly functioning testes (including absence of sperm from the semen or azoospermia) caused by an extra X chromosome.

- Sertoli-cell only syndrome – Under this condition, the sperm - producing cells, germ cells, are absent.

Financial, Social, and Medical Impact of Proposed Mandates

Sperm production disorders

These factors can inhibit the production of sperm.

- Varicocele – Defects in the valves of testicular veins create a bundle of enlarged, varicose veins around the testicles. This produces an abnormal backflow of blood into the scrotum and causes a rise in temperature in the testes. This increase in temperature interferes with testosterone levels and the production of mature sperm.

- Azoospermia – This is the absence of sperm in the semen. Obstructive azoospermia occurs when sperm is produced normally but the tubes are blocked. The most common cause of obstructive azoospermia is vasectomy. In non-obstructive azoospermia, the tubes are open but the testes produce no sperm.

- Sperm morphology – The shape of the sperm prevents it from penetrating the egg.

- Poor sperm motility – The sperm may not have the ability to travel the length of the uterus.

- Adult mumps infection – If a man has mumps after puberty, the disease may destroy the ability of one or both testicles to produce sperm.

- Trauma to the testicles – An injury or trauma from surgery can damage the blood vessels that nourish the testicles.

- Prostate infection or prostatitis – Infection of the prostate gland can cause a decrease in sperm motility and count.

Ejaculation disorders

In the following conditions, sperm are produced and the tubes are unobstructed but the sperm do not get to the female.

- Retrograde ejaculation – Because of weakened nerves that normally regulate the bladder, sperm enters the man's bladder rather than the penis during orgasm. This condition can be caused by diabetes, prostate surgery, bladder surgery, and some medications.

- Impotence or erectile dysfunction (ED) – This is the inability of the penis to become erect and for the man to ejaculate.

Immunologic disorders

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- Endocrine disorders – Normally, the hypothalamus releases the hormone GnRH, which stimulates the pituitary gland to secrete the hormones LH and FSH. Normally, these hormones stimulate the maturation of the testes and the production of sperm. The cause can be:
  - Kallmann's syndrome, which is a failure of the hypothalamus to produce and release GnRH
  - Hypothyroidism or pituitary tumors
  - Other unexplained reasons for low levels of LH, FSH, or testosterone.

- Anti-sperm antibodies – While antibodies are the body's natural defense against foreign agents, some men develop antibodies that attack their own sperm. It paralyzes the sperm by causing them to clump together or it coats them so that they cannot fertilize the egg.

When it is not feasible to use the husband's sperm, donor sperm is an option. Anonymous donor sperm can be used. The sperm would be frozen and quarantined while the donor is undergoing screening for health risks such as sexually transmitted diseases. With a known donor, either fresh or frozen sperm can be used. The success rate is higher with fresh sperm.

Because the donor sperm is generally healthier than the husband's sperm, intrauterine insemination (IUI), possibly combined with ovulatory stimulation, may be attempted rather than IVF. IUI has a much lower success rate but is thousands of dollars less expensive.

IUI is a procedure where sperm is injected into the uterus through a catheter. It is performed when the woman is ovulating. The procedure may be combined with ovulatory stimulation through drugs or hormone treatment. The sperm are typically washed. Then the healthy, active sperm are selected for insemination.

As stated earlier, all carriers we surveyed cover IVF using the limitations permitted in the mandate. For a coverage issue like this, self-insured plans are administered in the same manner as the insured plans unless the employer requests different benefits for IVF. The State of Maryland's self-funded employee benefit program covers IVF using the limitations permitted in the mandate.

Our survey of collective bargaining agents shows that the level of support for this proposed mandate ranges from no interest to a high level of support, with about half of those surveyed giving the proposal a low priority.

Financial, Social, and Medical Impact of Proposed Mandates

Medical

In this section we address the following:

- What the medical community recognizes as being effective and efficacious in the treatment of these patients;
- Scientific and peer review literature published by the medical community on this topic; and
- Current practices of treating physicians.

With advances in treatment of male factor infertility, once impracticable cases can now be treated to produce the sperm required for IVF. The most severe form of male infertility is azoospermia and it was once considered untreatable. Azoospermia affects about 5% to 10% of infertile couples. Now sperm can be retrieved directly from either the epididymis or the testis. Testicular sperm extraction (TESE) can be used for both non-obstructive azoospermia and obstructive azoospermia. TESE uses a small biopsy of testicular tissue with a local anesthetic. Percutaneus epididymal sperm aspiration (PESA) is used in obstructive azoospermia cases. PESA involves use of a small needle and a local anesthetic to aspirate sperm from near the obstruction. PESA is simpler and quicker than TESE. Micro epididymal sperm aspiration (MESA) is a delicate surgical technique that uses a microscope to get sperm near the obstruction.

Intracytoplasmic sperm injection (ICSI) has significantly improved chances of a successful pregnancy in many IVF patients. With ICSI, a single sperm is injected into a mature egg. In cases of azoospermia, PESA, MESA, or TESE can be used to collect the sperm and then ICSI can be used to fertilize the egg. Also, ICSI is effective in male factor cases with low sperm mobility and abnormal morphology or shape of the sperm. According to the Reproductive Science Center (RSC), "ICSI increases the fertilization rate for couples with poor semen quality and makes it possible for men with no measurable sperm in the ejaculate to father a biological child." However, the RSC also notes that "eggs may be damaged and not survive the ICSI process."

Studies by Cornell University, Center for Male Reproductive Medicine and Microsurgery, found that retrieval of sperm from the testis or epididymis was associated with good pregnancy rates using IVF. The chances were further improved through ICSI. In a test of non-obstructive azoospermia, sperm were retrieved 58% of the time using TESE. ICSI was then used to fertilize the eggs. Of the 58% where sperm was retrieved, fertilization and subsequent embryo transfer occurred for all the couples.

Many forms of structural abnormalities can be treated; however, Kleinfelter's syndrome and Sertoli's-cell only syndrome have no known medical treatment except for sperm extraction to use in IVF with ICSI.

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Varicocele can be treated surgically. According to Resolve, The National Infertility Association, varicocele is present in about 40% of infertile males. Resolve says, "The results of varicocele repairs in thousands of men show an overall improvement in semen quality of about 60% to 70% and a pregnancy rate of about 40%."

Resolve also says the most common cause of obstructive azoospermia is vasectomy. It can commonly be corrected through a vasectomy reversal.

Endocrine disorders affect about 5% to 10% of males. Resolve reports that Kallmann's syndrome can be treated with hCG injections. Also, unexplained low levels of LH, FSH, or testosterone may be treated by prescribing hormones.

As for anti-sperm antibodies, there are several techniques of processing semen to collect antibody-free sperm. According to Resolve, "Collection of the sperm samples directly into a culture medium, followed by rapid washing of the sperm seem to increase the proportion of antibody-free sperma and to improve the fertilization rate for IVF."

While all of these forms of treatment are effective in treating male factor infertility, some genetic conditions associated with male factor infertility may be passed on to the offspring. According to RSC, the following risks apply to the newborn:

- Chromosome abnormalities – These conditions exist in about 5% to 16% of men with severe sperm abnormalities. The abnormalities can be diagnosed using a karyotype blood chromosome study. Men with this disorder have a greater risk of fathering a child with chromosome abnormality and infertility.

- Y chromosome microdeletions – This exists in 10% to 20% of men who have severe sperm abnormalities but appear to have normal chromosomes. With this condition, men are missing tiny areas of their Y chromosome (microdeletions) that cannot be picked up on a routine chromosome study. These areas are important for the production and development of sperm and may cause the infertility. This condition may be passed on to offspring.

- Cystic fibrosis (CF) and congenital absence of the vas deferens (CAVD) – CAVD is the cause of infertility in about 1% to 2% of infertility cases. CAVD is associated with an increased risk of carrying a gene that causes CF. Because CF is a recessively inherited condition, both parents must be carriers for the child to be at risk for CF.

RSC recommends that men with severe male infertility, who require IVF with ICSI, get appropriate testing before initiating infertility treatment.

When use of the husband's sperm is not a feasible option or he has a significant genetic disorder that he does not want to pass on to his offspring, donor sperm can be used with IUI or IVF. With

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IUI, the chance of conception is between 5% and 20% depending on factors such as the wife's age. Typically, after about six IUI cycles, half of the women treated will conceive.

The benefits of donor insemination include:

- The wife can experience pregnancy.
- The child has a biological link to one of the two parents.
- The husband can still participate by attending the inseminations.
- The procedure can be performed on an outpatient basis.

The disadvantages of donor insemination include:

- There is a slight risk of infection.
- There is a slight risk of puncturing the uterus during IUI.
- Some religious groups are opposed to donor insemination.
- If the fact that the husband is not the biological father is hidden from the child, the child may be traumatized when discovering it later in life.
- Depending on the selection of donor, there may not be any resemblance to the father.
- The donor's medical history may be incomplete, missing, or inaccurate.
- The husband's procreative desires may not be filled.

Financial, Social, and Medical Impact of Proposed Mandates

HB 1129: Health Insurance – Coverage for Vaccinations Against Meningococcal Disease

This bill would require coverage for vaccinations against meningococcal disease for an enrollee who is an on-campus resident student enrolled in an institution of higher education.

The report on this proposed mandate includes information from several sources to provide more than one perspective. As a result, it contains some conflicting information. Mercer's intent is to be unbiased. While we included only sources we consider credible, we do not state that a given source is more credible than another source. The reader is advised to weigh the evidence.

A discussion of financial, social, and medical impact of this proposal follows.

Financial

The average cost per vaccination is about $80. We assume that one Maryland resident college freshman is living on-campus per every 100 Maryland insurance contracts. Therefore, the cost per contract to cover the vaccination would be $0.80 per contract per year. This is a nominal cost. It does not include an offset from potential savings by preventing meningococcal disease. All carriers surveyed said they currently cover the vaccination; however, comments from students and health clinics contradict findings of our survey. We assume the marginal cost will equal 20% of the full cost.

The full and marginal costs are summarized below:

	Full Cost	Marginal Cost
Estimated cost of mandated benefits as a percentage of average cost per group policy	0.0%	0.0%
Estimated cost as a percentage of average wage	0.00%	0.00%
Estimated annual per-employee cost of mandated benefits for group policies	$0.80	$0.16

Social

In this section, we address the following:

- The extent to which vaccinations for meningococcal disease are generally obtained by a significant portion of the population;

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- The extent to which lack of coverage of vaccinations for meningococcal disease causes in individuals to avoid necessary health care treatments;
- The extent to which lack of coverage of vaccinations for meningococcal disease results in unreasonable financial hardship;
- The level of public demand for vaccinations for meningococcal disease;
- The level of interest of collective bargaining agents in negotiating privately for inclusion of coverage of vaccinations for meningococcal disease in group contracts; and
- The extent to which vaccinations for meningococcal disease are covered by self-funded employers in the state who employ at least 500 employees.

Since June 1, 2000, Maryland law has required students enrolled in an institution of higher education in Maryland and who live in on-campus student housing to be vaccinated against meningococcal disease. The only exemption is for students (or legal guardians of minor students) who sign a waiver after reading detailed information on the risks associated with meningococcal disease and the availability and effectiveness of a vaccine.

The Towson University Dowell Health Center reports having over 92% compliance with the vaccination program. The Center offers the vaccination for $82; however, they advise students to get the vaccination prior to arriving on campus. This cost should not be a financial hardship if the carrier does not cover the service, given that it is relatively small compared with all the other costs of on-campus residence such as for food, housing, and associated needs.

Currently, all carriers we surveyed cover the vaccination under insured plans. The benefit may be subject to deductible and coinsurance. If the deductible has not been satisfied through other health care expenses, even with coverage, the student may have to pay for the vaccination. For a coverage issue like this, self-insured plans are administered in the same manner as insured plans unless the employer requests different benefits for vaccinations. The State of Maryland's self-funded employee benefit program covers the serum through the prescription drug benefits and the physician charges come through the medical plan.

Our survey of collective bargaining agents shows that the level of support for this proposed mandate ranges from low to high, with most of those surveyed giving the proposal a high priority.

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Medical

In this section we answer the following questions related to vaccinations for meningococcal disease:

- Are vaccinations for meningococcal disease recognized by the medical community as being effective and efficacious in the treatment of patients?
- Are vaccinations for meningococcal disease recognized by the medical community in their scientific and peer reviewed literature?
- Are vaccinations for meningococcal disease available and used by treating physicians?

Meningococcal meningitis is a form of meningitis caused by the bacterium neisseria meningitides. Meningitis involves an inflammation of the meninges membranes around the brain and spinal cord. The inflammation can be acute and with sudden onset or it can be subacute with gradual onset. Symptoms may include fever, headache, stiff neck, aching muscles, nausea, and vomiting. If properly diagnosed, treatment with antibiotics and other drugs is generally effective. Most will recover quickly and completely, while others may need a lot of support and care for weeks or months. While most recover, death occurs in 10% to 15% of cases. Also, 10% to 15% of those who recover have permanent hearing loss, lose use of their arms or legs, become mentally retarded, or suffer seizures or stokes. Meningococcal meningitis is contagious.

Meningococcal meningitis has several strains or serogroups, A, B, C, Y, and W-135. Vaccination with the currently available quadrivalent meningococcal polysaccharide vaccine does not provide protection against serogroup B disease but is 80% to 95% effective against serogroups A, C, Y, and W-135. The American Academy of Pediatrics estimates that the vaccine is at least 60% effective against meningococcal meningitis.

According to the Meningitis Foundation of America:

- There are about 3,000 meningococcal meningitis cases each year, and 100 to 125 of the cases occur on college campuses.
- Meningococcal meningitis is transmitted through air droplets and direct contact with infected people.
- The incidence rate peaks in late winter and early spring when college is in session.
- Studies show that 15 to 24 year olds are at the greatest risk of getting meningococcal meningitis, and the rate of outbreaks at colleges has been increasing.

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- Students living in dormitories have a six-fold increased risk of getting meningococcal meningitis.

According to the Centers for Disease Control and Prevention:

> In a retrospective, cohort study conducted in Maryland for the period 1992-1997, 67 cases of meningococcal disease among persons aged 16-30 years were identified by active, laboratory-based surveillance. Of those cases, 14 were among students attending Maryland colleges, and 11 were among those in 4-year colleges. The overall incidence of meningococcal disease in Maryland college students was similar to the incidence in the U.S. population of persons the same age (1.74/100,000 vs. 1.44/100,000, respectively); however, rates of disease were elevated among students living in dormitories compared with students living off-campus (3.2/100,000 vs. 0.96/100,000, p=0.05).
>
> U.S. surveillance for meningococcal disease in college students was initiated in 1998; from September 1998 through August 1999, 90 cases of meningococcal disease were reported to CDC. These cases represent approximately 3% of the total cases of meningococcal disease that occur each year in the United States. Eighty-seven (97%) cases occurred in undergraduate students, and 40 (44%) occurred among the 2.27 million freshman students entering college each year. Among undergraduates, of the 71 (82%) isolates for which serogroup information was available, 35 (49%) were serogroup C, 17 (24%) were serogroup B, 15 (21%) were serogroup Y, and one (1%) was serogroup W-135. Eight (9%) students died. Of the five students who died for whom serogroup information was available, four had serogroup C isolates and one had serogroup Y.
>
> U.S. surveillance data from the 1998-1999 school year suggest that the overall rate of meningococcal disease among undergraduate college students is lower than the rate among persons aged 18-23 years who are not enrolled in college (0.7 vs. 1.5/100,000, respectively). However, rates were higher among specific subgroups of college students. Among the approximately 590,000 freshmen who live in dormitories, the rate of meningococcal disease was 4.6/100,000, higher than any age group in the population other than children aged <2 years, but lower than the threshold of 10/100,000 recommended for initiating meningococcal vaccination campaigns.

Overall, because of the low incidence rate of meningococcal meningitis, the Centers for Disease Control and Prevention does not recommend vaccination of all college students, all freshmen, or only freshmen who live in dormitories or residence halls. However, they do recommend that students be informed of the risk of the disease and the benefits of the vaccine. Their specific recommendation for college students is:

- Providers of medical care to incoming and current college freshmen, particularly those who plan to or already live in dormitories and residence halls, should, during routine medical care, inform these students and their parents about meningococcal disease and the benefits of vaccination. ACIP does not recommend that the level of increased risk among freshmen warrants any specific changes in living situations for freshmen.

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- College freshmen who want to reduce their risk for meningococcal disease should either be administered vaccine (by a doctor's office or student health service) or directed to a site where vaccine is available.

- The risk for meningococcal disease among non-freshmen college students is similar to that for the general population. However, the vaccine is safe and efficacious and therefore can be provided to non-freshmen undergraduates who want to reduce their risk for meningococcal disease.

- Colleges should inform incoming and/or current freshmen, particularly those who plan to live or already live in dormitories or residence halls, about meningococcal disease and the availability of a safe and effective vaccine.

- Public health agencies should provide colleges and health-care providers with information about meningococcal disease and the vaccine as well as information regarding how to obtain vaccine.

In contrast, the American Academy of Pediatrics supports immunization of college students, particularly college freshman living in dormitories.

Financial, Social, and Medical Impact of Proposed Mandates

SB 370: "Health Insurance Carriers – Standing Referrals to Specialists"

This proposal would expand the definition of specialist within the context of standing referrals to include anyone licensed, certified, or otherwise authorized under the Health Occupations Article to provide health care.

Currently, a specialist is defined as a physician certified or trained to practice in a specified field of medicine and who is not designated as a primary care physician. This bill would expand the definition of specialist to include anyone licensed, certified, or otherwise authorized under the Health Occupations Article to provide health care. The following non-physician providers could be added to the definition of specialists under the current direct referral requirement. (The governing title within the Health Occupations Article is shown in italics.)

- Acupuncturists *(Title 1A*)
- Audiologists, hearing aid dispensers, and speech-language pathologists (*Title 2)*
- Chiropractors *(Title 3)*
- Massage therapists *(Title 3)*
- Dietitians and nutritionists *(Title 5)*
- Electrologists *(Title 6)*
- Nurses, nurse midwives, and nursing assistants *(Title 8)*
- Occupational therapists *(Title 10)*
- Optometrists *(Title 11)*
- Physical therapists *(Title 13)*
- Physician assistants (*Title 15)*
- Podiatrists *(Title 16)*
- Professional counselors and therapists *(Title 17)*
- Psychologists *(Title 18)*
- Speech pathologists *(Title 20).*

The Health Occupations Article includes other professionals (such as morticians), but we did not consider them providers of covered health services as defined in the CSHBP.

This bill applies to four types of medical conditions:

- Life-threatening
- Degenerative
- Chronic
- Disabling.

Standing referrals to specialists would be covered under any of these conditions if the condition required specialized medical care, the specialist has expertise in treating the condition, and the specialist is part of the carrier's provider panel. If the carrier does not have a specialist with the

required expertise in its network, a specialist outside of the panel must be covered as long as the specialist agrees to accept the same reimbursement rate as a specialist who is part of the carrier's provider panel.

The standing referral would be subject to a written treatment plan developed by the primary care physician, the specialist, and the member. The treatment plan may limit the number of specialist visits, limit the period of time the specialist is authorized, and require the specialist to communicate regularly with the primary care physician. While the proposed mandate integrates the PCP, it does not require the integration of the appropriate specialist physician; therefore the specialist physician may be bypassed.

The report on this proposed mandate includes information from several sources to provide more than one perspective. As a result, it contains some conflicting information. Mercer's intent is to be unbiased. While we included only sources we consider credible, we do not state that a given source is more credible than another source. The reader is advised to weigh the evidence.

A discussion of financial, social, and medical impact of this proposal follows.

Financial

We assume that life-threatening conditions would be those such as cancer or AIDS; degenerative conditions could include osteoporosis and osteoarthritis; chronic conditions could include heart disease, back problems, and migraine headaches; and disabling conditions could include the prior two categories with conditions such as multiple sclerosis and paralysis. For these four types of conditions, the patients would be allowed a standing referral to any provider covered under the Health Occupations Article, including acupuncturists and chiropractors.

Aspects of this bill should lead to both increases and decreases in cost. Cost could **decrease** if the additional health care providers are less expensive than the current specialists providing care; the non-physician providers are as effective as physicians; and the service is used *in place of* physician specialist services rather than in addition to them. The bill could **increase** costs if the number of visits or scope of services or care for someone with a serious illness is not well managed. A patient may still need to visit the physician specialist in addition to the non-physician specialist.

Passage of this bill would also lead to increased awareness of non-physician specialists and the fact that services from these providers are covered. Through advertising, these non-physician specialists could recommend that patients see their primary care physicians about getting a referral. This would increase visits to primary care physicians to get a referral and the number of visits to non-physician specialists.

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We assume the annual number of visits to an acupuncturist, chiropractor, or massage therapist would increase by about 0.3 visits per member. This would be in addition to current physician visits rather than in place of them. Assuming a $60 benefit per visit, the additional annual cost would be $18 per member. With an average of 2.2 members per contract, the annual cost would be $40 per employee or 0.7% of premium. The cost could be higher if members see more of the other non-physician providers through the direct referral requirement, but it would not significantly affect these projections.

In Mercer's survey of Maryland carriers, we found that all carriers cover referrals to non-physician specialists to some degree but not to the degree proposed by the bill. We estimate that about 75% of the non-physician referral costs are currently covered, so the marginal annual cost would be $10 per contract or about 0.2% of premium. The carrier survey responses on expected additional cost ranged from no impact to a 0.2% increase in premium. The vast majority projected no impact on the premium.

The projected full cost and marginal cost are in the table below.

	Full Cost	Marginal Cost
Estimated cost of mandated benefits as a percentage of average cost per group policy	0.7%	0.2%
Estimated cost as a percentage of average wage	0.10%	0.03%
Estimated annual per-employee cost of mandated benefits for group policies	$40	$10

Many types of non-physician providers are not currently covered under the Health Occupations Article, and their services are not covered by this bill. If the Health Occupations Article were expanded to include other providers, those services would be covered automatically. Massage therapists were a recent addition to the Health Occupations Article and would not have been required to be included as a specialist before they were added.

If a patient with a life-threatening condition used this proposed mandate to abandon physician-based care, the patient's condition could deteriorate. If the patient then returned to physician-based care, the care required could be more intensive and costly, thereby increasing the cost of health care.

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Social

In this section, we address the following:

- The extent to which non-physician specialist services are generally utilized by a significant portion of the population;
- The extent to which lack of coverage of referrals to non-physician specialists causes individuals to avoid necessary health care treatments;
- The extent to which lack of coverage of referrals to non-physician specialists results in unreasonable financial hardship;
- The level of public demand for referrals to non-physician specialists;
- The level of interest of collective bargaining agents in negotiating privately for inclusion of coverage of referrals to non-physician specialists in group contracts; and
- The extent to which referrals to non-physician specialists are covered by self-funded employers in the state who employ at least 500 employees.

According to the Journal of the American Medical Association (JAMA), 42% of Americans sought alternative therapy in 1997. The therapies increasing most between 1990 and 1997 were herbal medicine, massage, megavitamins, self-help groups, folk remedies, energy healing, and homeopathy. JAMA's surveys found that alternative therapies were used most frequently for chronic conditions and pain management, such as for back problems, anxiety, depression, and headaches. A recent Harvard study showed that 60% of chronic pain sufferers use some form of alternative medicine. A 1993 study in the New England Journal of Medicine found that roughly one-third of alternative medicine focuses on health promotion and disease prevention – situations outside the scope of this mandate.

Many alternative therapies are not covered by health insurance. However, Kenneth Pelletier, director of the Complementary and Alternative Medicine Program at Stanford University, says that the number of insurers now offering alternative therapy coverage is rising exponentially. This response is being driven almost entirely by consumer demand. The most common treatments covered are chiropractic, acupuncture, biofeedback, massage, and homeopathy. Chiropractors, massage therapists, and acupuncturists are three of the providers included in the Health Occupations Article. According to surveys of employer-sponsored plans, as many as 90% of plans cover chiropractic care and 30% cover acupuncture. Although the alternative providers are currently included, coverage may not be available on a standing referral basis.

A number of plans offer discounts on alternative therapies. Blue Shield of California, for example, offers a 25% discount toward acupuncture, chiropractic, and nutrition treatments. Because this is a discount plan and the carrier is not at risk for reimbursement of services, no referral is required. Other insurers, such as American Western Life, Kaiser Permanente, Blue Cross/Blue Shield, Mutual of Omaha, and Prudential, offer limited coverage of some alternative care. The Oxford Health Plan has established an alternative medicine practice for participants who do not need to see a primary care provider first for permission to receive alternative treatments.

But patients often still face barriers in getting adequate coverage for alternative therapies. Insurance companies will cover an alternative treatment only if it is deemed medically necessary, and they greatly limit the number of visits covered per year. Pelletier says "medically necessary" is a vague notion, and what one practitioner regards as medically necessary, another may not. This proposed mandate could make the existence of a life-threatening, degenerative, chronic, or disabling condition the only requirement and thereby replace the current inconsistent definition of medical necessity.

Chiropractors are allowed to bill Medicare and are also reimbursed for care provided under workers' compensation programs, and 26 states cover chiropractic care under Medicaid. Approximately 12% to 15% of Americans receive chiropractic treatments. According to a use of alternative care survey by David Eisenburg, MD, of Harvard University and Beth Israel Deaconess Medical Center in Boston, chiropractic therapy ranks fourth in alternative medicines, following relaxation techniques, herbal medicine, and message therapy.

Forty-five states require private insurance to cover chiropractic care; 11 states have mandates for acupuncturists; and two states have mandates for naturopaths. No governmental payers currently cover acupuncturists or naturopaths.

Overall, lack of coverage should not result in avoidance of necessary health care treatments. Maryland's supply of physicians is higher than the national average, so they should be able to provide necessary care. Some would argue that by having a standing referral to non-physician specialists, patients might avoid the necessary physician care and thereby forgo necessary health care treatments.

Also, should alternative care be the necessary health care treatment, it is worth noting that non-physicians are not the only practitioners providing alternative therapies. Physicians are also pursuing the education they need to administer these treatments. John S. Gordon, chair of the White House Commission on Complementary and Alternative Medicine Policy, says, "There's much more interest in complementary medicine now…three-quarters of medical schools now have elective courses in complementary medicine," as opposed to 20 years ago when only two schools offered them.

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Where non-physician specialists serve a rural population and physician resources are unavailable, lack of coverage could result in unavailability of necessary health care treatments. However, according to the MHCC 1998 Practitioner Utilization and Expenditures Report, Maryland has had a steady supply of physicians (approximately 35% above the national level).

Without this mandate, a referral is required for services provided by a non-physician specialist. If the referral is not provided, services from the non-physician specialist may not be covered and the patient may be responsible for the cost. The referral may not cover an extended treatment plan by the non-physician specialist. This mandate requires a written treatment plan. The treatment plan may limit the number of visits or period of time the specialist is authorized. The cost of alternative therapies provided by non-physician specialists varies widely. For treatments extending over a long period of time (for example, repeated acupuncture sessions for chronic pain), the lack of coverage might result in unreasonable financial hardship. If the treatment plan were approved by the primary care physician, this mandate would eliminate the cost of getting repeated referrals. The cost of a referral should not present a financial hardship.

The level of public demand for alternative therapies is increasing. Reasons include consumer frustration with the limitations of traditional medicine, a growing body of scientific literature that links disease to nutritional and emotional factors, and a greater awareness of the medical practices of other cultures. Whereas only 33% of Americans were using alternative therapies in 1990, 42% were using them by 1997. More insurers are offering alternative therapy coverage to attract additional enrollees and to retain current enrollees interested in alternative therapies. The supply of non-physician specialists in the alternative disciplines of chiropractic, acupuncture, and naturopathy has grown rapidly in the last decade and is projected to grow at an even faster rate in the next decade. In fact, some aggressive bills before Congress would mandate a vast expansion of patients' access to non-physician specialists. The presence of these bills indicates public demand.

The responses from Mercer's survey of collective bargaining agents range from giving the proposal a high priority to giving it a low priority. No clear preference was expressed.

Mercer's survey of carriers in the Maryland market reveals that about 75% of referrals are currently covered; however, none of the carriers surveyed cover non-physician specialists as broadly as the proposal. For a coverage issue like this, self-insured plans are administered in the same manner as the insured plans. The State of Maryland's employee benefit program covers chiropractic care and acupuncture, but it does not cover biofeedback, massage, or homeopathy.

The *Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans* shows that, in 2001, 27% of plans covered acupuncture/acupressure therapy, 16% of plans covered massage therapy, and 82% of plans covered chiropractic therapies. Coverage of these providers has increased since 1998 when 17% covered acupuncture/acupressure, 10% covered massage, and

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61% of plans covered chiropractic therapies. Those plans covering these providers may not allow direct referral and may have a limit on the number of visits covered.

Medical

In this section we answer the following questions about referrals to non-physician specialists:

- Is care by non-physician specialists recognized by the medical community as being effective and efficacious in the treatment of patients?
- Is care by non-physician specialists recognized by the medical community as shown by a review of scientific and peer review literature?
- Is referral care to non-physician specialists available and utilized by treating physicians?

Alternative medicine is used in place of the standard medical treatment, whereas complementary therapy, or fusion medicine, is used along with standard medical treatment.

Many patients seek complementary care without informing their physicians; therefore, creating disjointed care. In a survey of 50 men undergoing radiation treatment for prostate cancer, more than a third were using complementary therapy, while the patients' physicians had estimated that only about 4% were using complementary therapy. In some cases, patients tell their physicians about their use of alternative therapy, but when the physicians show no interest, the patients continue their therapy without further physician consultation. As more patients try alternative therapies, the potential risk of a clash with Western medical care increases.

Researchers are beginning to pay more attention to alternative therapies. According to Jeffrey White, MD, who heads the research program on complementary and alternative medicine at the National Cancer Institute (NCI), "More and more physicians are discovering that some of these approaches really do have something to offer." According to scientists at the National Institutes of Health (NIH) six out of 10 cancer patients try complementary therapy. The NIH recently established the National Center for Complementary and Alternative Medicine (NCCAM) to explore the field.

Generally, the medical community agrees that non-physician specialists are effective and efficacious in the treatment of patients when they:

- Work under the supervision of a physician
- Stay within their level of training and expertise
- Provide a complementary component of traditional treatment.

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Physician organizations and non-physician specialist organizations sometimes disagree on the role of non-physician specialists. The main issue is whether they are collaborative or competitive with physicians. Cedars-Sinai Medical Center in Los Angeles offers massage, acupuncture, and other complementary therapy in combination with their standard medical treatment. The Center claims that results are excellent.

Numerous studies have evaluated the effectiveness of alternative treatments for various ailments. The Complementary and Alternative Medicine (CAM) Citation Index (CI), developed by the National Center for Complementary and Alternative Medicine, contains approximately 180,000 bibliographic citations from 1963 through 1999. Unfortunately, many of these studies did not meet traditional clinical standards for design or execution, so it is difficult to rely on their results. In 1997 Congressional testimony, Beth Israel Deaconess Medical Center said:

> Despite findings that confirm extensive use of alternative therapy in the United States and internationally, relatively little is known about the safety, efficacy, cost-effectiveness and mechanism of action of individual alternative therapies. In short, there is a paucity of satisfactory research involving alternative medical interventions.

NCCAM is beginning to conduct and support basic and applied research and training and to disseminate information on complementary and alternative medicine to practitioners and the public. More medically credible research on alternative therapy is expected in the future.

Acupuncture therapy

Researchers of acupuncture believe that the needles stimulate the nervous system to release chemicals and hormones that relieve pain. The biochemical changes may stimulate the body's natural healing abilities and promote physical and emotional well being.

In 1997, the National Institutes of Health convened a panel of experts to examine the research on the efficacy of acupuncture. The panel found acupuncture clearly effective for postoperative pain from dental surgery and for nausea and vomiting due to chemotherapy and anesthesia. They said it might be effective for migraines, tennis elbow, arthritis, menstrual cramps, and low-back pain. Its effectiveness was uncertain for stroke rehabilitation, asthma, carpal tunnel syndrome, and immune system enhancement.

According to the American Academy of Medical Acupuncture, acupuncture is most useful for musculoskeletal pain:

> In the United States, acupuncture has found its greatest acceptance and success in the management of musculoskeletal pain. Acute musculoskeletal lesions such as soft tissue contusions, acute muscle spasms, musculotendinous sprains and strains, and the pain of acute nerve entrapments are among the problems most frequently and successfully addressed with acupuncture. In such cases, acupuncture can legitimately serve as the initiating therapy.

> Chronic musculoskeletal pain problems are also commonly and appropriately treated with acupuncture, although not usually as the only approach. Those problems likely to be responsive to acupuncture intervention include repetitive strain disorders (e.g., carpal tunnel syndrome, tennis elbow, plantar fascutis), myofascial pain patterns (e.g., temporomandibular joint pain, muscle tension headaches, cervical and thoracic soft tissue pain, regional shoulder pain), arthralgias (particularly osteoarthritic in nature), degenerative disc disease with or without radicular pain, and pain following surgical intervention (both musculoskeletal and visceral). In the management of chronic musculoskeletal pain, acupuncture offers a broad range of potential value between the conventional therapy poles of pharmaceuticals and invasive procedures. Other chronic pain problems commonly responsive to acupuncture include postherpetic neuralgia, peripheral neuropathic pain, and headaches from other causes.

While acupuncture needles were once on the FDA's list of experimental devices, they are now regulated as a medical device. This is a sign of acceptance of acupuncture as a legitimate treatment.

Acupuncture is a part of many drug treatment programs because, with repeated treatment, it reduces craving, improves sleep, and helps people think more clearly. In a study of treatment for cocaine addiction, Yale researchers determined that acupuncture was effective when combined with Western treatment. The 82 patients were divided into three groups:

- One received acupuncture in areas of the outer ear thought to be associated with addiction.
- A control group received acupuncture in areas of the outer ear believed not to be associated with addiction.
- A control group saw videos depicting relaxing images.

After 8 weeks of treatment, 53.8% of patients receiving acupuncture therapy for addiction tested free of cocaine compared with 23.5% and 9.1% in the two control groups.

According to WebMD, "Certain people should not have acupuncture, including those who are pregnant, have heart-valve diseases, bleeding disorders, pacemakers, irregular heartbeats, or epilepsy as well as those who use blood-thinning medication.

In a study by Yuan-Chin Lin, MD, of Harvard Medical School and Children's Hospital in Boston, 243 children received acupuncture treatments for one year to treat conditions such as lower back, hip, lower extremity, and abdominal pain, and headaches. Using a scale of 1 to 10, where 10 was most painful, the children ranked their pain. Before treatment, the average ranking was 8. A year later, the average ranking was 3, and they reported no side effects or complications.

Since 1997, Phoenix Memorial Hospital has been treating emergency room patients with a combination of Western medicine and acupuncture for conditions ranging from headache and backache pain to anxiety, depression, and stress-related illnesses. They found that:

- 62% of 16 patients treated for severe headache pain were pain-free or had 80% pain relief.
- 30% of 77 patients who had fractures, sprains, or strains were entirely or almost pain-free, before applying casts, when pain is normally severe.
- 42% of 12 patients who had pain from toothaches, carpal tunnel syndrome, or tennis elbow were pain-free.

Traditional Chinese medicine has also used acupuncture to improve fertility. In a German study of 160 women receiving in vitro fertilization (IVF), women receiving acupuncture had a higher pregnancy rate. In the IVF-only group, 21 of the 80 women (26.3%) became pregnant. The other 80 women received acupuncture as part of their treatment, and 34 (42.5%) became pregnant.

More physicians are becoming trained in acupuncture. Acupuncture is taught as a continuing education class at UCLA's medical school. According to the American Academy of Medical Acupuncture, about 500 physicians in the U.S. obtained training in Chinese medicine that met international standards in 1999.

Massage therapy

Massage therapy has been part of many physical rehabilitation programs and has been beneficial for people with many chronic conditions such as low back pain, arthritis, and bursitis.

Tiffany Field, PhD, a psychologist and director of the Touch Therapy Institute at the University of Miami School of Medicine, has led 83 studies looking at the effect of massage on depression, pain, autism, autoimmune disorders such as asthma and diabetes, and immunity. Her findings include the following:

- Premature babies who were massaged three times a day had 47% more weight, were discharged six days earlier, and had about $10,000 lower hospital costs.
- Depressed mothers who received massages twice a week before delivery had lower levels of cortisol, which reduced their risk of premature delivery. The mothers also had less risk of postpartum depression, and none of the babies were born with high levels of cortisol, which affects babies' development.
- Asthmatic children who received massage therapy had increased air movement, better lung function, less anxiety, and reduced stress.
- Children with attention deficit hyperactive disorder who received massage therapy twice a week for one month began to spend more time on tasks.
- Autistic children who received massage therapy paid more attention to sounds, were more sensitive to touch, and related to teachers better.
- Diabetic children who received massage therapy had glucose levels fall to the normal range and were better able to follow dietary requirements.

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Chiropractic therapy

Chiropractic treatment is based on the theory that many medical disorders may be caused by dislocations in the spine, or vertebral subluxations. The treatment involves adjusting the joints and bones of the spine through twisting, pulling, or pushing movements. Treatment may be preceded by the use of heat, electrical stimulation, or ultrasound to help relax the muscles. It is used to treat many conditions including osteoarthritis, lumbar facet syndrome, failed back surgery, herniated discs, fibromyalgia, and cervical neck pain.

Chiropractic treatment gained recognition in 1994 when the U.S. Agency for Health-Care Policy and Research endorsed chiropractic manipulation over surgery and acupuncture as one of the few effective treatments for some forms of lower back pain.

According to WebMD:

> Chiropractic treatment can be a safe treatment for certain conditions when done by a certified and experienced chiropractor who correctly diagnoses the problem. However, if an incorrect diagnosis is made, appropriate medical treatment may be delayed. Although rare, the most serious risks associated with chiropractic treatment are stroke and spinal cord injury after cervical (neck) manipulation.
>
> Other side effects may include minor pain or discomfort at the point of manipulation, headaches, and fatigue. Most of these effects resolve within a day.
>
> If an incorrect diagnosis is made, chiropractic treatment can be harmful. Rarely, chiropractic treatment can worsen a herniated or slipped disc.

Chiropractic manipulation is even safe in the third trimester of pregnancy and can help with various pregnancy-related problems. During pregnancy, a women's back takes the burden of up to an extra 25 to 35 pounds. At the same time, hormones prepare her body for childbirth by loosening spinal and pelvic ligaments, and the expanding uterus weakens the abdominal muscles. Lower back pain and sciatica commonly result. Chiropractic therapy treats the misalignment and alleviates the symptoms.

Published research and clinical experience have also shown success in turning breech babies and reducing labor pain through chiropractic treatments. The manipulation method to treat breech babies was developed by chiropractor Larry Webster, who claims a 97% success rate. Other chiropractors claim success rates of about 85%.

Pregnancy-related referrals to chiropractors are common among midwives but are rare in the traditional obstetric community.

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Additional forms of complementary therapy

While other practitioners of alternative and complementary medicine may not be currently covered by the Health Occupations Article, there is always a chance that the Article will be expanded to include them.

For example, according to Daniel L. Handel, MD, of the National Institutes of Health, "There is strong scientific evidence of the efficacy of hypnosis for control of pain, anxiety, sleep problems, and nausea and vomiting associated with chemotherapy."

About 90% of people are hypnotizable to some extent, making it a practicable form of treatment.

Hypnosis has also been used to treat obesity through controlling eating behavior by temporarily relieving cravings for food. Studies have shown sustained weight losses of between 7 and 20 pounds with the use of hypnosis alone or in conjunction with other treatment.

According to the American Society of Clinical Hypnosis (ASCH), hypnosis has been successfully used as complementary therapy in the following medical treatments and psychotherapy:

- Gastrointestinal Disorders (Ulcers, Irritable Bowel Syndrome, Colitis, Crohn's Disease).
- Dermatologic Disorders (Eczema, Herpes, Neurodermatitis, Pruritus [itching], Psoriasis, Warts).
- Surgery/Anesthesiology (In unusual circumstances, hypnosis has been used as the sole anesthetic for surgery, including the removal of the gall bladder, amputation, cesarean section, and hysterectomy. Reasons for using hypnosis as the sole anesthetic may include: situations where chemical anesthesia is contraindicated because of allergies or hyper-sensitivities; when organic problems increase the risk of using chemoanesthesia; and in some conditions where it is ideal for the patient to be able to respond to questions or directives from the surgeon.)
- Pain (back pain, cancer pain, dental anesthesia, headaches and migraines, arthritis or rheumatism).
- Burns: Hypnosis is not only effective for the pain, but when hypnotic anesthesia and feelings of coolness are created in the first few hours after a significant burn, it appears that it also reduces inflammation and promotes healing. ASCH believes that a second degree burn can often be kept from going third degree if hypnosis is used soon after the injury.
- Nausea and Vomiting associated with chemotherapy and pregnancy (hyperemisis gravidarum).
- Childbirth: Based upon our members' anecdotal evidence, approximately two-thirds of women have been found capable of using hypnosis as the sole analgesic for labor. This eliminates the risks that medications can pose to both the mother and child.
- Hemophilia: Hemophilia patients can often be taught to use self-hypnosis to control vascular flow and keep from requiring a blood transfusion.
- Victims of Abuse (incest, rape, physical abuse, cult abuse).

- Other areas of application include: Allergies; anxiety and stress management; asthma; bed-wetting; depression; sports and athletic performance; smoking cessation; obesity and weight control; sleep disorders; Raynaud's disease; high blood pressure; sexual dysfunctions; concentration, test anxiety, and learning disorders.

Although the medical community encourages members to educate themselves about alternative therapies and to be open to working with patients and clinicians to integrate these treatments, peer literature also indicates that caution is warranted when it comes to untested medical treatments. An article in *Annuals of Internal Medicine* presents a comprehensive risk-minimizing strategy for physicians in advising patients who seek alternative care. A 1998 editorial in the *New England Journal of Medicine* presents the most conservative position on alternative medicine treatments:

> It is time for the scientific community to stop giving alternative medicine a free ride. There cannot be two kinds of medicine – conventional and alternative. There is only medicine that has been adequately tested and medicine that has not, medicine that works and medicine that may or may not work…Alternative treatments should be subjected to scientific testing no less rigorous than that required for conventional treatments.

Despite the need for more research, patients are demanding alternative treatment options. According to a spokesperson for the American Medical Association, "The AMA encourages doctors to become aware of alternative therapies and use them when and where appropriate." Similarly, the American Academy of Pediatrics has no specific policy on alternative treatments but encourages patients to do their own investigation and encourages physicians to be open-minded.

Financial, Social, and Medical Impact of Proposed Mandates

Mental Illness Coverage Period for Children

We were asked to review a request to require coverage for inpatient treatment of acute or chronic mental illness at a hospital or residential treatment center (RTC) for children under the age of 18 years, from the date of admission to the date the child becomes potentially eligible for coverage under the Maryland Medical Assistance Program.

The definition of an RTC under Health-General, §19-301(p) is "a psychiatric institution that provides campus-based intensive and extensive evaluation and treatment of children and adolescents with severe and chronic emotional disturbances who require a self-contained therapeutic, educational, and recreational program in a residential setting." An accredited RTC is an RTC accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Under Maryland's mental health parity mandate, the child should be covered for hospital inpatient care until the child is potentially eligible under Medicaid. This proposal would expand mental health coverage for children to include admissions to residential treatment centers.

If the length of stay exceeds 30 days, a child is considered a "family of one" and is eligible for coverage under Medicaid. However, it takes time for Medicaid to determine eligibility. Upon determining the child's eligibility, Medicaid pays for coverage dating back to the first day of the month in which a child became eligible. On average, for a RTC admission, this would leave a coverage gap of 15 days without Medicaid coverage.

The report on this proposed mandate includes information from several sources to provide more than one perspective. As a result, it contains some conflicting information. Mercer's intent is to be unbiased. While we included only sources we consider credible, we do not state that a given source is more credible than another source. The reader is advised to weigh the evidence.

A discussion of the financial, social, and medical impact of this proposal follows.

Financial

Based on a Mercer survey of managed behavioral health care vendors, for a commercial population (employer-sponsored plans) we estimate there are about two residential treatment center admissions annually for every 10,000 members. In a study of 20 residential treatment programs in Connecticut, the average length of stay was 298 days. We assume that all RTC admissions will have a length of stay that meets or exceeds the Medicaid eligibility requirement. Assuming that RTCs are available, each year two in every 10,000 children require a RTC admission, and 15 average days per admission not covered by Medicaid, the uncovered days would be three per 1,000 children.

Cost per day for residential treatment centers varies by facility and level or model of care. Many facilities contract only with Medicaid and are not prepared to accept patients covered by commercial contracts. We surveyed JCAHO accredited RTCs across the country and for those facilities that accept patients outside of Medicaid, the rate for a commercial population ranges from $350 to $450 per day. For our projections, we assumed that a child may be placed out-of-state and the average cost per day will be $400 for a comprehensive program, including psychiatric consultations.

The Maryland Department of Health and Mental Hygiene (DHMH) has contracts with 14 accredited RTCs in Maryland and four accredited RTCs that are out-of-state. For fiscal year 2003, the Medicaid reimbursement rates range by facility from $183 to $367 per day. The average Medicaid rate for the Maryland RTCs is $340 per day. DHMH does not expect that many of these facilities would be able to accept patients outside of Medicaid.

Assuming three days per 1,000 children and $400 per day, the cost per child is $1.20 annually. Using an average of 0.6 children per contract, the cost per contract is $0.72 annually, or a nominal percentage of premium. Carriers we surveyed generally say that RTCs are covered for non-custodial care if it is the most appropriate place of treatment; however, one prominent carrier admitted that their network does not currently include any RTCs. We estimate that 25% of the cost of care prior to potential eligible under Medicaid is already covered; therefore the marginal cost equals 75% of the full cost.

The full and marginal costs are summarized below:

	Full Cost	Marginal Cost
Estimated cost of mandated benefits as a percentage of average cost per group policy	0.0%	0.0%
Estimated cost as a percentage of average wage	0.00%	0.00%
Estimated annual per-employee cost of mandated benefits for group policies	$0.72	$0.54

Social

In this section, we address the following:

- The extent to which inpatient treatment of mental illness for children at RTCs is generally utilized by a significant portion of the population;

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- The extent to which lack of coverage of RTCs for inpatient treatment of mental illness for children results in individuals avoiding necessary health care treatments;
- The extent to which lack of coverage of RTCs for inpatient treatment of mental illness for children results in unreasonable financial hardship;
- The level of public demand for coverage of RTCs for inpatient treatment of mental illness for children;
- The level of interest of collective bargaining agents in negotiating privately for inclusion of expansion of coverage of RTCs for inpatient treatment of mental illness for children in group contracts; and
- The extent to which RTCs for inpatient treatment of mental illness for children are covered by self-funded employers in the state who employ at least 500 employees.

Maryland's mental health parity mandate, enacted in 1994, requires a carrier (health insurer, nonprofit health services plan, or HMO) to provide coverage for mental health services on the same terms as physical illness. Carriers must cover a minimum of 60 days of partial hospitalization for mental illness. Also, as to inpatient coverage of services provided in a licensed or certified facility including a hospital, the total number of days covered and the terms of coverage must be at least equal to those that apply to the benefits available under the policy for physical illness. Benefits may be provided through a carrier's managed care system.

Before the mental health parity mandate, benefit costs were managed through limited benefit maximums. Since implementation of the mental health parity mandate, carriers have turned to managed care systems to control costs. These managed care systems, along with more effective diagnosis and treatment, have reduced the use of mental health care services. The Maryland Health Resources Planning Commission reported a decrease in inpatient stays in psychiatric units of general hospitals one year after the passage of Maryland's parity law. In 1995, 11 people were hospitalized for more than 60 days, which is significantly lower than the 21 people in 1993. In 1995, 18% of cases in private psychiatric hospitals were stays of longer than 24 days, which is significantly lower than the 24% of cases in 1993.

One report on residential treatment use by children estimated that 35,000 children and adolescents used residential treatment centers in 1985 (Milazzo-Sayre, as cited in Krohn, 2000); however, use has been increasing. Another report stated that the use of residential treatment centers had risen from 6% of child and adolescent mental health service expenditures in 1986 to 28% of expenditures in 1991 (Burns, as cited in Krohn, 2000). In many cases, there is no local residential treatment center with capacity and the only available center is out of state.

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Overall, the level of public demand for coverage of RTCs is low because of the low incidence rate among the general population. However, for those who need the service, the demand for either residential treatment center or in-home care is high, because of the perceived difference it makes in the quality of life.

The responses from our survey of collective bargaining agents range from giving the proposal a high priority to giving it a low priority. The most common response was a high level of interest.

Based on responses from managed behavioral health care vendors, we estimate that few employers cover long term RTC admissions.

The State of Maryland, Department of Budget and Management, Employee Benefits Division told Mercer that mental health coverage for state employees is administered by a managed behavioral health care vendor and that the benefit plan has excluded RTC treatment. The vendor does cover hospitalization, partial hospitalization (4 to 10 hours a day), intensive outpatient care, occasional overnight partial hospitalization, and outpatient services. The vendor says that it is not unusual for its clients to exclude coverage for RTCs. This vendor was not one of the managed behavioral health care vendors included in Mercer's survey.

Medical

In this section we answer the following questions related to RTC services:

- Are RTC services recognized by the medical community as being effective and efficacious in the treatment of patients?
- Are RTC services recognized by the medical community as demonstrated by a review of scientific and peer review literature?
- Are RTC services available and utilized by treating physicians?

In the article *Randomized Trial of General Hospital and Residential Alternative Care for Patients With Severe and Persistent Mental Illness,* 185 adult patients who were enrolled in the Montgomery County Department of Mental Health's mental health program were randomly assigned to either Montgomery General Hospital in Olney, Maryland, or a residential alternative care facility, McAuliffe House in Rockville, Maryland. In a survey conducted six months following discharge, psychosocial functioning, satisfaction, and acute care use were comparable for the two treatment settings. While the average length of stay for the alternative care facility was longer than for the hospital (18.7 days compared to 11.7 days), the cost per day for the alternative care facility was about half the cost per day for the hospital. Overall, the cost per admission for the alternative treatment facility was about half the cost per admission for the hospital.

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RTCs are institutions that serve children who have difficulty maintaining socially appropriate behavior and functioning in academic, social, and family settings. Frequently, a child is admitted to an RTC because parents, teachers, or police are too burdened – not because of specific symptoms or risk behaviors. One study, based on surveys of RTC staff, estimates that two-thirds of the children in RTC could have been placed in a less restrictive setting if one were available (Hoagwood & Cunningham, as cited in Krohn, 2000). Placement for care seems to be based more on availability than on the most appropriate level of care.

The paper *Children and Adolescent Residential Treatment Centers: An Evaluation of Treatment Efficacy* states:

> RTCs as a whole have evolved into placements for children and adolescents with behavior problems. Generally, RTCs serve a combination of children with behavioral, emotional, or mental health symptoms, but the portion of children with mental health diagnoses (e.g., thought, mood, and anxiety disorders) has been declining. The typical RTC, though a great variety of models exists, is oriented toward the conduct-disoriented male. For example, more children are transferred to RTCs from detention centers than to any other placement.

The paper also states that, while the evidence is limited, there are studies that have demonstrated positive RTC treatment outcomes with:

- Children 13 years of age and younger (Prentice-Dunn)
- Children who had shorter stays (Hoagwood and Cunningham)
- Children who did not exhibit psychosis, neurological dysfunction, or antisocial behavior (Blotcky)
- Children (juvenile offenders in RTCs) whose treatment plan included family therapy (93% recidivism without family therapy) (Borduin)
- Children who had adequate time in the program and adequate aftercare services (Blotcky).

Cognitive-behavioral therapy was successful in reducing externalizing behavior, such as aggression, although the behavior remained within the clinically abnormal range. Programs that showed the greatest gain focused on developing academic and vocational skills, as well as providing strong case management that coordinated services with family, school, and community.

Other studies show that there is little efficacy in RTCs. For example:

- One study showed that 63% of the children and adolescents at discharge had either minimal or no treatment gains. Also, the more restrictive the treatment setting, the less effective the treatment (Hoagwood and Cunningham, as cited in Krohn, 2000).

- RTCs have less of a tendency to individualize a treatment program to the individual's needs than community-based programs (Lyons, as cited in Krohn, 2000).

Financial, Social, and Medical Impact of Proposed Mandates

Alternatives to RTC care may be as effective or even more effective. Day treatment programs have been shown to be as effective as RTC care, with the advantages of costing less, requiring minimal disruption to school and social life, and avoiding the institutional stigma. Also, wrap-around community-based programs have been shown to reduce subsequent RTC admissions. In a Canadian study, a 15-hour weekly individualized treatment program was perceived by case managers, parents, and children as effective, while costing only 16% of the combined average cost of all out-of-home placements (Brown & Hill, as cited in Krohn, 2000).

Mental Health: A Report of the Surgeon General reported the following findings relating to care of children and adolescents:

- Research on partial hospitalization/day treatment as an alternative to inpatient treatment generally finds benefit from a structured daily environment that allows youth to return home at night to be with family and friends.

- Day treatment has been used as a transitional service after residential treatment when 24-hour care is no longer needed but the youth is not ready to be reintegrated into the school system.

- Research on day treatment points to positive gains related to academic and behavioral improvement, reduction in or delay of hospitalization or RTC placement, and about a 75% return-to-school rate for patients, but most studies are uncontrolled.

- Family participation during and following day treatment is essential for optimal results.

- One of the concerns about RTC is the risks of treatment, including failure to learn behavior needed in the community, the possibility of trauma associated with the separation from the family, difficulty reentering the family or even abandonment by the family, victimization by RTC staff, and learning of antisocial or bizarre behavior from intensive exposure to other disturbed children.

- Home-based services provide very intensive services within the youth's home in order to prevent out-of-home placement.

Research generally seems to show that RTCs are appropriate in some cases but that in most cases patients do not benefit from the treatment. RTCs have the drawbacks of being costly, separating the patient from family and friends (in many cases the only available RTC is out of state), and not being coordinated with community-based care. Its advantages are that it is less costly than inpatient care and it is successful in some cases.

In-home care, community-based care, and day treatment seem to offer benefits similar to RTCs, excluding the most severe cases. These alternatives are also less costly than RTCs and can

incorporate the family into the care of the patient. They also tend to be more individualized than RTCs and may better meet the patient's needs.

Affordability Cap on Mandates

Under Sections 15-1501 and 15-1502 of the Insurance Article, the MHCC is required to annually determine the full cost of all existing mandated health insurance services in Maryland as a percentage of:

- Maryland's average annual wage
- Average health insurance premium.

The Commission is required to consider the full cost of existing mandates under:

- A typical group and individual health benefit plan in the State
- The State employee health benefit plan for medical coverage
- The Comprehensive Standard Health Benefit Plan (CSHBP).

If the cost of the current mandates equals or exceeds 2.2% of the State's average annual wage, the Commission must evaluate the financial, social, and medical impact of each existing mandated health insurance service and report to the General Assembly on its findings. Then the General Assembly must determine whether to enact new mandated health insurance services or repeal existing ones. A copy of this section of the Insurance Article is included as Exhibit 3.

This report focuses on benefit requirements included under Subtitle 8 of Title 15 of Maryland's Insurance Law. MHCC staff prepared a summary of the Subtitle 8 mandates that is included as Exhibit 4. **Based on 2001 estimated expenses and wages, the full cost for these mandates is 2.19% of the Maryland average annual wage, which is barely below the 2.2% affordability cap.** Therefore, the Commission does not need to conduct a full evaluation of the fiscal, social, and medical impact of existing mandates this year.

The difference between the current cost of mandates and the affordability cap is about 0.01% of the average wage. Because the rate of increase in health care costs continues to exceed the rate of increase in wages, even without the addition or expansion of mandates, we expect that the cost of mandates will exceed the ceiling in next year's review.

When expressing the cost of the mandates as a percentage of the average annual wage, Mercer did not have the wage segregated by type of delivery system; therefore, we used the same wage base for all types of contracts. The average annual wage in 2001 was $38,329, based on statistics from the DLLR. The cost of the mandates does, however, vary by type of contract because of differences in the number of members per contract, the relative morbidity of the different groups, the employee out-of-pocket costs (deductible and coinsurance), and other factors. The affordability cap is based on the composite full cost of mandates across all types of groups. The cap is not applied separately by type of group. Carriers do not track the costs of the mandates for different types of policies; therefore, the cost had to be estimated.

While the composite cost is below the cap, the full cost of current mandates for individual policies is estimated to be 2.9% of the Maryland average wage. This is higher because of the higher use of services and higher administrative expenses for individual policies.

Affordability Cap on Mandates

Using the wage data from the DLLR, the average wage cannot be determined for individual policyholders. If the average wage for these policyholders is less than the State average, then the financial cost (for the higher premium resulting from the mandates) relative to wages would be higher when expressed as a percentage of the average policyholder's wages. The cost relationship by policyholder type should be considered by the legislature even if the composite cost is used when determining whether the affordability cap has been exceeded. The cost impact on individual policyholders is particularly important because these persons are likely paying out of pocket for coverage because they have a perceived need for the coverage. When expressed as a percentage of premium, the cost of mandated benefits for individual policies is about the same as for group insurance. Because the individual policies are more costly (due to higher use of health care services and higher administration expenses per member) the full cost of mandates for an individual policy is estimated to be $1,123 annually per policy as compared to a group policy, where the cost is estimated to be $864 annually per policy.

There is one other issue to examine, and that is the mandates included under group contracts in other states in the Mid-Atlantic region. If Maryland wants to attract and retain employers, it must make sure that it does not put an undue burden on employers relative to neighboring states. Exhibit 5 is a summary of the group health insurance mandates by state. We prepared this exhibit by segregating benefit mandates into the following 30 types of health care services and treatment:

- AIDS
- Alcohol/ substance abuse
- Cleft lip and cleft palate
- Clinical trials
- Colorectal cancer screening
- Contraceptives
- Dental procedures
- Diabetes
- Drugs and supplies
- Emergency treatment
- Fertility treatment
- Hemophilia
- Home health care
- Hospice
- Mammography screening
- Mastectomy
- Maternity care
- Mental health treatment
- Nursing home
- Obesity
- Other mandated conditions
- Ovarian cancer
- Pap smears

Affordability Cap on Mandates

- Prostate cancer
- Prosthetics
- Reconstructive breast surgery
- Second opinion
- TMJ
- Well child care
- Wellness (*excluding well child care, prostate cancer screening, Pap smears, mammography screening, and ovarian cancer screening).*

Mercer compared mandates for the following states using on the corresponding sources:

State	Insurance Code
Maryland	Maryland Code Annotated
Delaware	Delaware Code
District of Columbia	District of Columbia Code
New Jersey	New Jersey Statutes Annotated
New York	New York Insurance Law
Pennsylvania	Pennsylvania Unconsolidated Statutes
Virginia	Virginia Code Annotated & Virginia Administrative Code

Two states may have mandates that are significantly different but that address the same health services. A short description of each state's mandate is included in Exhibit 5. The following table summarizes how many of these 30 benefits are mandated by each state in the Mid-Atlantic region.

State	Number of Benefit Mandates
Delaware	16
District of Columbia	11
Maryland	25
New Jersey	20
New York	22
Pennsylvania	14
Virginia	24

Affordability Cap on Mandates

This would indicate that, given the number of benefits mandated, Maryland has the highest burden; however, this does not take into account the relative cost of the mandates.

Looking at just the 25 benefits mandated in Maryland, the following table shows how many of these mandates also exist in the other Mid-Atlantic states:

State	Number of Maryland Benefit Mandates
Delaware	14
District of Columbia	9
Maryland	25
New Jersey	17
New York	20
Pennsylvania	13
Virginia	21

Of the Maryland mandates, the most expensive group insurance mandate based on full cost is for mental health and substance abuse benefits, at about 0.7% of the Maryland average wage. All of the other Mid-Atlantic states have mental health mandates. All of them also have alcohol or substance abuse treatment mandates.

The next most expensive mandate based on full cost is hospitalization for childbirth, at about 0.4% of the Maryland average wage. This includes a mandate on the minimum length of stay, which all the other Mid-Atlantic states also address.

All of the other Mid-Atlantic states address coverage for diabetes equipment and supplies, mammograms, reconstructive breast surgery, and well child care.

Looking at just the five benefits not mandated in Maryland (AIDS treatment, hemophilia treatment, ovarian cancer screenings, Pap smears, and wellness care), the following table shows the number of these mandates that exist in the other Mid-Atlantic states:

Affordability Cap on Mandates

State	Number of Non-Maryland Benefit Mandates
Delaware	2
District of Columbia	2
Maryland	0
New Jersey	3
New York	2
Pennsylvania	1
Virginia	3

This shows that the other states have the burden of some additional mandates that do not exist in Maryland; however, these additional mandates do not create a significant financial burden.

Although Exhibit 5 indicates that Maryland has more mandates than the other Mid-Atlantic states, it also shows that the more costly mandates are covered by most of these states. This would suggest that Maryland may be *perceived* as a state with a high burden of mandates, and this may add to the administrative burden of the plans. However, the financial burden of group mandated benefits does not seem significantly higher in Maryland than in other Mid-Atlantic states because all Mid-Atlantic states cover the most expensive mandates.

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Maryland Health Care Commission

Financial Analysis of Current Mandates

			Relative Cost Factor						Estimated Annual Cost of Mandated Benefits Per Group Policy		Estimated Cost of Mandated Benefits as a Percent of Average Cost Per Group Policy		Estimated Cost as a Percent of Average Wage	
	Code	Mandate or Required Offering	HMO	Non-Profit Health Service Plan	Group Insurance	Individual Insurance	CSHBP	Maryland State Employee Plan	Full Cost	Marginal Cost	Full Cost	Marginal Cost	Full Cost	Marginal Cost
Current Mandates														
Alzheimer's	15-801	RO		1.0	1.0		-	1.0	$0	$0	0.0%	0.0%	0.00%	0.00%
Mental illness, emotional disorders, drug & alcohol abuse	15-802	M		1.0	1.0	1.3	0.9	1.0	$278	$28	5.0%	0.5%	0.73%	0.07%
Payment for blood products	15-803	M	0.9	1.0	1.0	1.3	0.9	1.0	$26	$0	0.5%	0.0%	0.07%	0.00%
Coverage for off-label use of drugs	15-804	M	0.9	1.0	1.0	1.3	-	1.0	$14	$3	0.2%	0.1%	0.04%	0.01%
Reimbursement for pharmaceutical products	15-805	M		1.0	1.0	1.3	-	1.0	$7	$1	0.1%	0.0%	0.02%	0.00%
Choice of pharmacy	15-806	M		1.0			-		$71	$57	1.3%	1.0%	0.19%	0.15%
Medical foods & modified food products	15-807	M		1.0	1.0	1.3	0.9	1.0	$3	$1	0.1%	0.0%	0.01%	0.00%
Home health care	15-808	M		1.0	1.0	1.3	0.9	1.0	$25	$3	0.4%	0.1%	0.07%	0.01%
Hospice care	15-809	RO		1.0	1.0	1.3	0.9	1.0	$0	$0	0.0%	0.0%	0.00%	0.00%
In vitro fertilization	15-810	M	0.9	1.0	1.0	1.3	-	1.0	$26	$21	0.5%	0.4%	0.07%	0.05%
Hospitalization benefits. for childbirth	15-811	M		1.0	1.0	1.3	0.9	1.0	$116	$2	2.1%	0.0%	0.30%	0.01%
IP hosp. coverage for mothers of newborn children (minimum length of stay)	15-812	M	0.9	1.0	1.0	1.3	0.9	1.0	$55	$44	1.0%	0.8%	0.14%	0.11%
Benefits for disability caused by pregnancy or childbirth	15-813	RO			1.0		-	1.0	$0	$0	0.0%	0.0%	0.00%	0.00%
Coverage for mammograms	15-814	M		1.0	1.0	1.3	0.9	1.0	$28	$11	0.5%	0.2%	0.07%	0.03%
Coverage for reconstructive breast surgery	15-815	M	0.9	1.0	1.0	1.3	0.9	1.0	$8	$5	0.1%	0.1%	0.02%	0.01%
Benefits for routine gynecological care	15-816	M	0.9	1.0	1.0	1.3	0.9	1.0	$0	$0	0.0%	0.0%	0.00%	0.00%
Coverage for child wellness	15-817	M		1.0	1.0	1.3	0.9	1.0	$45	$14	0.8%	0.2%	0.12%	0.04%
Benefits for treatment of cleft lip and cleft palate	15-818	M		1.0	1.0	1.3	0.9	1.0	$14	$3	0.2%	0.1%	0.04%	0.01%
Coverage for OP services and second opinions	15-819	M		1.0	1.0	1.3	-	1.0	$1	$0	0.0%	0.0%	0.00%	0.00%

Maryland Health Care Commission

Financial Analysis of Current Mandates

			Relative Cost Factor						Estimated Annual Cost of Mandated Benefits Per Group Policy		Estimated Cost of Mandated Benefits as a Percent of Average Cost Per Group Policy		Estimated Cost as a Percent of Average Wage	
	Code	Mandate or Required Offering	HMO	Non-Profit Health Service Plan	Group Insurance	Individual Insurance	CSHBP	Maryland State Employee Plan	Full Cost	Marginal Cost	Full Cost	Marginal Cost	Full Cost	Marginal Cost
Current Mandates														
Benefits for prosthetic devices and orthopedic braces	15-820	M		1.0			0.9		$6	$0	0.1%	0.0%	0.02%	0.00%
Diagnostic & surgical procedures for bones of face, head, & neck	15-821	M		1.0	1.0	1.3	0.9	1.0	$16	$8	0.3%	0.1%	0.04%	0.02%
Coverage for diabetes equipment, supplies, & self management training	15-822	M	0.9	1.0	1.0	1.3	0.9	1.0	$33	$13	0.6%	0.2%	0.09%	0.03%
Coverage for osteoporosis treatment	15-823	M	0.9	1.0	1.0	1.3	0.9	1.0	$26	$7	0.5%	0.1%	0.07%	0.02%
Coverage for maintenance drugs	15-824	M	0.9	1.0	1.0	1.3	0.9	1.0	$4	$2	0.1%	0.0%	0.01%	0.01%
Coverage for detection of prostate cancer	15-825	M	0.9	1.0	1.0	1.3	0.9	1.0	$40	$20	0.7%	0.4%	0.10%	0.05%
Coverage for contraceptives	15-826	M	0.9	1.0	1.0	1.3	0.9	1.0	$11	$6	0.2%	0.1%	0.03%	0.02%
Coverage of clinical trials under specifi conditions	15-827	M	0.9	1.0	1.0	1.3	0.9	1.0	$11	$10	0.2%	0.2%	0.03%	0.03%
Coverage for general anesthesia for dental care under specified conditions	15-828	M	0.9	1.0	1.0	1.3	0.9	1.0	$1	$0	0.0%	0.0%	0.00%	0.00%
Chlamydia screening based on age and risk factors	15-829	M	0.9	1.0	1.0	1.3	0.9	1.0	$4	$1	0.1%	0.0%	0.01%	0.00%
Referrals to specialists	15-830	M	0.9	1.0	1.0	1.3	0.9	1.0	$2	$1	0.0%	0.0%	0.01%	0.00%
Coverage for prescription drugs and devices	15-831	M	0.9	1.0	1.0	1.3	0.9	1.0	$1	$1	0.0%	0.0%	0.00%	0.00%
Coverage for length of stay for mastectomies	15-832	M	0.9	1.0	1.0	1.3	0.9	1.0	$1	$1	0.0%	0.0%	0.00%	0.00%
Extension of benefits	15-833	M	0.9	1.0	1.0	1.3	0.9	1.0	$1	$1	0.0%	0.0%	0.00%	0.00%
Coverage for prosthesis following mastectomy	15-834	M	0.9	1.0	1.0	1.3	0.9	1.0	$0	$0	0.0%	0.0%	0.00%	0.00%
Coverage of habilitative services for children	15-835	M	0.9	1.0	1.0	1.3	0.9	1.0	$0	$0	0.0%	0.0%	0.00%	0.00%

Maryland Health Care Commission

Financial Analysis of Current Mandates

			Relative Cost Factor						Estimated Annual Cost of Mandated Benefits Per Group Policy		Estimated Cost of Mandated Benefits as a Percent of Average Cost Per Group Policy		Estimated Cost as a Percent of Average Wage	
	Code	Mandate or Required Offering	HMO	Non-Profit Health Service Plan	Group Insurance	Individual Insurance	CSHBP	Maryland State Employee Plan	Full Cost	Marginal Cost	Full Cost	Marginal Cost	Full Cost	Marginal Cost
Current Mandates														
Coverage for wigs for hair loss resulting from chemotherapy	15-836	M	0.9	1.0	1.0	1.3	-	1.0	$0	$0	0.0%	0.0%	0.00%	0.00%
Coverage for routine gynecological care by OB/GYN provider	15-816 expan-sion	M	0.9	1.0	1.0	1.3	0.7	1.0	$0	$0	0.0%	0.0%	0.00%	0.00%
Standing referral to obstetrician for pregnancy	15-816 expan-sion	M	0.9	1.0	1.0	1.3	0.7	1.0	$0	$0	0.0%	0.0%	0.00%	0.00%
IVF for male factor infertility reduce 5 year infertility history requirement	15-810 expan-sion	M	0.9	1.0	1.0	1.3	-	1.0	$18	$14	0.3%	0.2%	0.05%	0.04%
Coverage for Colorectal cancer screening	15-837	M	0.9	1.0	1.0	1.3	0.9	1.0	$7	$1	0.1%	0.0%	0.02%	0.00%
Coverage for hearing aids for a minor child	15-838	M	0.9	1.0	1.0	1.3	-	1.0	$8	$8	0.1%	0.1%	0.02%	0.02%
Coverage for treatment of morbid obesity	15-839	M	0.9	1.0	1.0	1.3	-	1.0	$29	$20	0.5%	0.4%	0.08%	0.05%
Habilitative services – modification and clarification	15-835	M	0.9	1.0	1.0	1.3	0.9	1.0	$3	$2	0.1%	0.0%	0.01%	0.01%
Coverage of residential crisis services	15-840	M	0.9	1.0	1.0	1.3	0.9	1.0	$2	$0	0.0%	0.0%	0.01%	0.00%

Maryland Health Care Commission

Financial Analysis of Current Mandates

			Relative Cost Factor						Estimated Annual Cost of Mandated Benefits Per Group Policy		Estimated Cost of Mandated Benefits as a Percent of Average Cost Per Group Policy		Estimated Cost as a Percent of Average Wage	
	Code	Mandate or Required Offering	HMO	Non-Profit Health Service Plan	Group Insurance	Individual Insurance	CSHBP	Maryland State Employee Plan	Full Cost	Marginal Cost	Full Cost	Marginal Cost	Full Cost	Marginal Cost
Current Mandates														

Summary by Type of Policy

									Estimated Annual Cost of Mandated Benefits Per Policy		Estimated Cost of Mandated Benefits as a Percent of Average Cost Per Policy		Estimated Cost as a Percent of Average Wage	
Type of Policy									Full Cost	Marginal Cost	Full Cost	Marginal Cost	Full Cost	Marginal Cost
HMO									$298	$163	5.9%	3.2%	0.78%	0.43%
Non-Profit Health Service Plan									$941	$309	16.8%	5.5%	2.46%	0.81%
Group Insurance									$864	$252	15.4%	4.5%	2.25%	0.66%
Individual Insurance									$1,123	$328	15.4%	4.5%	2.93%	0.85%
CSHBP									$690	$167	14.1%	3.4%	1.80%	0.43%
State Employees Benefit Plan									$896	$261	16.0%	4.7%	2.34%	0.68%
Composite									$841	$237	15.0%	4.2%	2.19%	0.62%

Maryland Health Care Commission

Financial Analysis of Proposed Mandates

		Relative Cost Factor				Estimated Annual Cost of Mandated Benefits Per Group Policy		Estimated Cost of Mandated Benefits as a Percent of Average Cost Per Group Policy		Estimated Cost as a Percent of Average Wage	
	Mandate or Required Offering	Group Insurance	Individual Insurance	CSHBP	Maryland State Employee Plan	Full Cost	Marginal Cost	Full Cost	Marginal Cost	Full Cost	Marginal Cost
Proposed Mandates											
HB 738: "Health Insurance Carriers – In Vitro Fertilization – Conditions for Provision of Benefits"	M	1.0	1.3		1.0	$0.50	$0.50	0.0%	0.0%	0.00%	0.00%
HB 1129: "Health Insurance – Coverage for Vaccinations Against Meningococcal Disease"	M	1.0	1.3		1.0	$0.80	$0.16	0.0%	0.0%	0.00%	0.00%
SB370: "Health Insurance Carriers – Standing Referrals to Specialists"	M	1.0	1.3		1.0	$40	$10	0.7%	0.2%	0.10%	0.03%
Mental Illness Coverage Period for Children	M	1.0	1.3		1.0	$0.72	$0.54	0.0%	0.0%	0.00%	0.00%

Summary by Type of Policy

Estimated Cost By Type of Policy						Estimated Annual Cost of Mandated Benefits Per Policy		Estimated Cost of Mandated Benefits as a Percent of Average Cost Per Policy		Estimated Cost as a Percent of Average Wage	
						Full Cost	Marginal Cost	Full Cost	Marginal Cost	Full Cost	Marginal Cost
Proposed Mandates:											
Group Insurance						$42	$11	0.7%	0.2%	0.11%	0.03%
Individual Insurance						$54	$15	0.7%	0.2%	0.14%	0.04%
CSHBP						$0	$0	0.0%	0.0%	0.00%	0.00%
State Employees Benefit Plan						$43	$12	0.8%	0.2%	0.11%	0.03%

EXHIBIT 4

Insurance Law

Subtitle 8

Required Health Insurance Benefits

Updated as of October 22, 2002

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
		HMO	Non Profit	Group Ins.	Indiv. Ins.		
801	Benefits for Alzheimer's disease and care of elderly individuals		X	X		Health insurers must offer the option of including benefits for the expenses arising from the care of victims of Alzheimer's disease and the care of the elderly to all group purchasers.	Not specifically addressed as covered or excluded; could be covered by .03 A (28): "Any other service approved by a carrier's case management program"

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
		HMO	Non Profit	Group Ins.	Indiv. Ins.		
802	Benefits for treatment of mental illnesses, emotional disorders, and drug and alcohol abuse	19-703.1	X	X	X	All policies providing coverage for health care may not discriminate against any person with a mental illness, emotional disorder, or drug abuse or alcohol abuse disorder by failing to provide benefits for treatment and diagnosis of these illnesses under the same terms and conditions that apply under the contract or policy for treatment of physical illness. **Inpatient:** Physical illness parity with a minimum of at least 60 days of partial hospitalization; **Outpatient:** 80% coverage for first 5 visits in any calendar year or benefit period; 65% coverage for 6-30 visits; 50% coverage for 31st visit and any visits after the 31st. **Scope:** medically necessary; One set of benefits covering mental illness, emotional disorders, drug abuse and alcohol abuse; may be delivered under a managed care system; cannot maintain separate out-of-pocket limits; medication management visit same as physical illness office visit	**.03 A (4):** "Inpatient mental illness and substance abuse services provided through a carrier's managed care system up to a maximum of 60 days per covered person per year in a hospital or related institution" **.03 A (5):** "Outpatient mental health and substance abuse services provided through a carrier's managed care system" **.03 A (7):** "Detoxification in a hospital or related institution" **.03 C:** "All mental health and substance abuse services described in § A (4) and (5) of this regulation shall be delivered through a carrier's managed care system" **.05 A:** "General Cost-Sharing Arrangement for Outpatient Mental Health and Substance Abuse Services." Except for out-of-network services of this regulation, "...the carrier shall pay for each service 70 percent of allowable charges"

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
		HMO	Non Profit	Group Ins.	Indiv. Ins.		
803	Payments for blood products	X 19-706(r)	X	X	X	Health insurers may not exclude payments for blood products	Covered; .03 A (24): "All cost recovery expenses for blood, blood products, derivatives, components, biologics, and serums to include autologous services, whole blood, red blood cells, platelets, plasma, immunoglobulin, and albumin"
804	Coverage for off-label use of drugs	X 19-706(i)	X	X	X	Requires coverage for approved off-label drugs	
805	Reimbursement for pharmaceutical products		X	X	X	Subject policies cannot establish varied reimbursement based on the type prescriber and cannot vary copayments based on community pharmacy vs. mail order	
806	Choice of pharmacy for filling prescriptions		X			The non-profit health service plan shall allow the member to fill prescriptions at the pharmacy of choice	
807	Coverage for medical foods and modified food products	19-705.5	X	X	X	All insurers shall include under family member coverage, coverage for medical foods and low protein modified food products for the treatment of inherited metabolic diseases if the medical foods or low protein modified food products are: (1) prescribed as medically necessary for therapeutic treatment of inherited metabolic diseases; and, (2) administered under the direction of a physician	Covered; .03 A (21): "Medical food for persons with metabolic disorders when ordered by a health care practitioner qualified to provide diagnosis and treatment in the field of metabolic disorders"

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
		HMO	Non Profit	Group Ins.	Indiv. Ins.		
808	Benefits for home health care		X	X	X	Health insurance policies that provide coverage for inpatient hospital care on an expense-incurred basis must provide coverage for home health care. The minimum benefit is 40 visits in any calendar year	Covered; .03 A (11): "Home health care services…as an alternative to otherwise covered services in a hospital or related institution;…"
809	Benefits for hospice care		X	X	X	Health insurers must offer individuals and groups benefits for hospice care services	Covered; .03 A (12): "Hospice care services"
810	Benefits for in vitro fertilization (IVF)	X	X	X	X	Carriers that provide pregnancy-related benefits may not exclude benefits for all outpatient expenses arising from IVF procedures. The benefits shall be provided to the same extent as benefits provided for other pregnancy-related procedures. The patient or the patient's spouse must have a history of infertility of at least 2 years or have become infertile from endometriosis, exposure to DES, blockage or removal of fallopian tubes, or abnormal male factors. Carriers may limit coverage of these benefits to 3 IVF attempts per live birth, not to exceed a maximum lifetime benefit of $100,000.	Excluded; .06 B (11): "In vitro fertilization, ovum transplants and gamete intrafallopian tube transfer, zygote intrafallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures"
811	Hospitalization benefits for childbirth	19-703 (g)	X	X	X	Every insurance policy that provides benefits for normal pregnancy must provide hospitalization benefits to the same extent as that for any covered illness	Covered; .03 A (25): "Pregnancy and maternity services, including abortion" §15-811 Adopted as mandate

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
		HMO	Non Profit	Group Ins.	Indiv. Ins.		
812	Inpatient hospitalization coverage for mothers and newborn children	X 19-706(i)	X	X	X	Requires carriers to provide inpatient hospitalization coverage for a mother and newborn child for a minimum of 48 hours after an uncomplicated vaginal delivery and 96 hours after an uncomplicated caesarean section; authorizes a home visit by an experienced registered nurse if the mother requests a shorter hospital stay and an additional home visit if prescribed by the provider; authorizes coverage for up to four additional days for a newborn when the mother continues to be hospitalized; and prohibits sanctions against a provider who advocates a longer stay	Covered; Required by §19-1305.4; effective 7/1/96; §15-812 adopted as mandate
813	Benefits for disability caused by pregnancy on childbirth			X		Insurers must offer to groups purchasing a temporary disability policy the option of extending these benefits to temporary disabilities caused by pregnancy or childbirth	Disability caused by pregnancy/childbirth: Not addressed.
814	Coverage for mammograms		X	X	X	All hospital and major medical insurance policies must include coverage for a baseline mammogram for women who are 35 to 39, a biannual mammogram for women who are 40 to 49, and an annual mammogram for women who are at least 50	Covered; .03 A (10): "Mammography services for persons ages 40 to 49 once every other calendar year, and for ages 50 and above once per calendar year"
815	Coverage for reconstructive breast surgery	X 19-706 (d)(2)	X	X	X	Requires carriers to provide coverage for reconstructive breast surgery resulting from a mastectomy to reestablish symmetry between the two breasts	Covered; .03 A (30): "Breast reconstructive surgery as specified in Insurance Article, § 15-815, Annotated Code of Maryland, and breast prosthesis"

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
		HMO	Non Profit	Group Ins.	Indiv. Ins.		
816	Benefits for routine gynecological care	X 19-706 (l)	X	X	X	Requires carriers to permit a woman to have direct access to gynecological care from an in-network obstetrician/ gynecologist or other non-physician, including a certified nurse midwife, who is not her primary care physician; requires an obstetrician/ gynecologist to confer with a primary care physician	§15-816 adopted as mandate
817	Coverage for child wellness services		X	X	X	Insurers must include child wellness services in a family policy. Minimally, this must include coverage for immunizations, PKU test, screening tests (tuberculosis, anemia, lead toxicity, hearing & vision), universal hearing screening of newborns; a physical exam, developmental assessment & parental anticipatory guidance services at each visit; and lab tests. Insurers may impose copayments but no deductible	Covered; in accordance with the schedule in the U.S. Preventive Services Task Force Guidelines
818	Benefits for treatment of cleft lip and cleft palate	19-706 (bb)	X	X	X	Every hospital or major medical insurance policy must include benefits for inpatient or outpatient expenses arising from the management of cleft lip, palate, or both	Covered; .03 A (23): "...habilitative services for children 0 to 19 years old for the treatment of congenital or genetic birth defects"
819	Coverage for outpatient services and second opinions		X	X	X	Health insurers must provide reimbursement for a second opinion when denied hospital admission by a utilization review program and when required by a utilization review program and outpatient coverage for a service for which an admission is denied	No specific references.

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
		HMO	Non Profit	Group Ins.	Indiv. Ins.		
820	Benefits for prosthetic devices and orthopedic braces.		X			Individual and group contracts written by a non-profit health service plan must provide benefits for prosthetic devices and orthopedic braces	Covered; .03 A (13): "Durable medical equipment, including nebulizers, peak flow meters, prosthetic devices such as leg, arm, back, or neck braces, artificial legs, arms, or eyes, and the training necessary to use these prostheses"
821	Diagnostic and surgical procedures for bones of face, neck, and head		X	X	X	Health insurers that provide coverage for a diagnostic or surgical procedure involving a bone or joint of the skeletal structure may not exclude or deny coverage for the same diagnostic or surgical procedure involving a bone or joint of the face, neck, or head if the procedure is medically necessary to treat a condition caused by a congenital deformity, disease, or injury.	Covered; .06 B (43): "TMJ treatment and treatment for CPS" are excluded, EXCEPT "for surgical services for TMJ and CPS, if medically necessary and if there is a clearly demonstrable radiographic evidence of joint abnormality due to disease or injury"
822	Coverage for diabetes equipment, supplies, and self-management training	X 19-706(x)	X	X	X	Carriers shall provide coverage for all medically appropriate and necessary diabetes equipment, diabetes supplies, and diabetes outpatient self-management training and educational services, including medical nutrition therapy for insulin users, non-insulin users, or elevated blood glucose levels induced by pregnancy	Provides coverage for all medically necessary supplies and equipment; includes 6 nutritional visits. Does not include other educational services.
823	Coverage for osteoporosis prevention and treatment	X 19-706(p)	X	X	X	Carrier shall include coverage for qualified individuals for bone mass measurement when requested by a health care provider	Covered under terms of "medical necessity" as of July 1, 1998; §15-823 adopted as mandate

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
		HMO	Non Profit	Group Ins.	Indiv. Ins.		
824	Coverage for maintenance drugs	X 19-706(q)	X	X	X	Carrier shall allow the insured to receive up to a 90-day supply of a prescribed maintenance drug in a single dispensing, except for new prescriptions or changes in prescriptions. If carrier increases copayment, they shall proportionally increase the dispensing fee.	As of July 1, 1998 copayment will be $30 (twice normal $15) Regs. modified .03 E (i) – (s); effective July 1, 2000 , 2-time single dispensing fee is: 2 x generic @ $15 or $30; 2 x pref. @ $20 or $40; 2 x non-pref. @ $30 or $60
825	Coverage for detection of prostate cancer	X 19-706(u)	X	X	X	Coverage shall be provided for a medically recognized diagnostic examination including a digital rectal exam and prostate – specific antigen (PSA) test for: 1) men between 40 & 75; 2) when used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment; 3) when used for staging in determining the need for a bone scan in patients with prostate cancer; or 4) when used for male patients who are at high risk for prostate cancer.	As of July 1, 1998 adopts American Cancer Society recommendations: 1) annual DRE for both prostate and colorectal cancer beginning at age 40; 2) annual PSA for African American men and all men age 40 or older with a family history of prostate cancer; and 3) an annual PSA screening for all other men age 50 and older.
826	Coverage for contraceptive drugs and devices	X 19-706(i)	X	X	X	Coverage shall be provided for 1) any contraceptive drug or device that is approved by the U.S. F.D.A. for use as a contraceptive and that is obtained under a prescription written by an authorized prescriber; 2) the insertion or removal, and any medically necessary exam associated with the use of such drug or device. An entity may not impose a different copay or coinsurance for a contraceptive drug or device that is imposed for any other Rx.	Covered, effective July 1, 1999; .03 A (22): "Family planning services, including: (a) Prescription contraceptive drugs or devices…"
827	Coverage for patient cost for clinical trials	X 19-706 (aa)	X	X	X	Coverage shall be provided for patient cost to a member in a clinical trial as a result of 1) treatment provided for a life-threatening condition; or 2) prevention , early detection, and treatment studies on cancer.	Covered; .03 A (27): "Controlled clinical trials"

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
		HMO	Non Profit	Group Ins.	Indiv. Ins.		
828	Coverage for general anesthesia for dental care under specified conditions	X 19-706 (i)	X	X	X	Coverage shall be provided for general anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care provided to an enrollee or insured under specified conditions.	Covered, effective July 1, 1999; .03 A (32): "General anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care provided to the following…"
829	Coverage for detection of chlamydia	X	X	X	X	Coverage shall be provided for an annual routine chlamydia screening test for women who are under the age of 20 if they are sexually active and at least 20 if they have multiple risk factors; and for men who have multiple risk factors	Covered, effective July 1, 2000; .03 A (33): An annual chlamydia screening test for women who are younger than 20 years old who are sexually active or at least 20 years old who have multiple risk factors and men who have multiple risk factors.
830	Referrals to specialists	X	X	X	X	Requires carriers that do not allow direct access to specialists to establish & implement a procedure by which a member may receive under certain circumstances a standing referral to a participating specialist & under certain circumstances to a non-participating specialist; provides pregnant members with a standing referral to an OB	§15-830 adopted as part of the "Patients' Bill of Rights Act," effective Nov. 1, 1999; standing referral for pregnancy adopted, effective October 1, 2000
831	Coverage of prescription drugs and devices	X	X	X	X	Each entity limiting its coverage of Rx drugs or devices to those in a formulary shall establish & implement a procedure for a member to receive a Rx drug or device that is not in the entity's formulary when there is no equivalent Rx drug or device in the entity's formulary, an equivalent Rx drug is ineffective or has caused an adverse reaction	§15-831 adopted as part of the "Patients' Bill of Rights Act," effective Nov. 1, 1999

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
		HMO	Non Profit	Group Ins.	Indiv. Ins.		
832	Coverage for mastectomies	X	X	X	X	Requires carriers to cover at least 1 home health visit within 24 hrs. after discharge for a patient who had <48 hrs. of inpatient hospitalization after a mastectomy or surgical removal of a testicle, or who undergoes either procedure on an outpatient basis	§15-832 adopted as part of the "Patients' Bill of Rights Act," effective Nov. 1, 1999
833	Extension of benefits	X	X	X	X	Requires carriers to extend certain benefits under specific circumstances except when coverage is terminated because of specified conditions. Charging of premiums is prohibited when benefits are extended	Law impacted CSHBP; effective Oct. 1, 1999
834	Coverage for prostheses	X	X	X	X	Requires carriers to provide coverage for a prosthesis prescribed by a physician for a member who has undergone a mastectomy & has not had breast reconstruction	Covered; .03 A (30): "Breast reconstructive surgery as specified in Insurance Article, § 15-815, Annotated Code of Maryland, and breast prosthesis
835	Coverage for habilitative services for children under 19 years of age	X	X	X	X	Requires carriers to provide coverage of habilitative services for children under the age of 19 years with a congenital or genetic birth defect, including autism & cerebral palsy, and may do so through a managed care system; carriers must provide notice annually to its members about the required coverage; carriers are not required to reimburse for habilitative services delivered through early intervention or school services; carriers denying payment for services because it is not a congenital or genetic birth defect is considered an adverse decision.	Covered; .03 B; Coverage shall be provided through the carrier's managed care system

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
		HMO	Non Profit	Group Ins.	Indiv. Ins.		
836	Hair prosthesis	X	X	X	X	Requires carriers to provide one hair prosthesis at a cost not to exceed $350 for a member whose hair loss results from chemotherapy or radiation treatment for cancer	Excluded; .06 B (40); "Wigs or cranial prosthesis"
837	Colorectal cancer screening coverage	X	X	X	X	As of July 1, 2001, carriers shall provide coverage for colorectal cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society (ACS)	As of July 1, 2001, adopts ACS recommendations: colorectal screening covered for men & women ages 50 and older as follows: a) a yearly FOBT w/DRE & flexible sigmoidoscopy every 5 yrs.; b) colonoscopy w/DRE every 10 yrs.; or c) double contrast barium enema w/DRE every 5 yrs.
838	Hearing aid coverage for a minor child	X	X	X	X	As of October 1, 2001, carriers shall provide coverage for hearing aids for a minor child covered under a policy if the hearing aids are prescribed, fitted, and dispensed by a licensed audiologist. Carriers may limit the benefit to $1,400 per hearing aid for each hearing-impaired ear every 36 months	Covered; .03 A (34), effective July 1, 2002: "…hearing aids for persons ages 0 to 18 years of age, up to $1,400 per hearing aid for each hearing-impaired ear every 36 months"

Insurance Code	Mandate	Affected Carriers				Description	CSHBP Coverage
		HMO	Non Profit	Group Ins.	Indiv. Ins.		
839	Coverage for treatment of morbid obesity	X	X	X	X	As of October 1, 2001, carriers shall provide coverage for the treatment of morbid obesity through gastric bypass surgery or another surgical method that is: 1) recognized by the NIH as effective for the long-term reversal of morbid obesity; and 2) consistent with criteria approved by the NIH. Carriers shall provide coverage for this benefit to the same extent as for other medically necessary surgical procedures under the insured's policy.	Excluded; .06 B (14): "Medical or surgical treatment for obesity, unless otherwise specified in the covered services"
840	Coverage for medically necessary residential crisis services	X	X	X	X	As of October 1, 2002, carriers shall provide coverage for medically necessary residential crisis services defined as intensive mental health & support services 1) provided to a child or an adult with a mental illness at risk of a psychiatric crisis; 2) designed to prevent or provide an alternative to a psychiatric inpatient admission, or shorten the length of inpatient stay; 3) provided at the residence on a short-term basis; and 4) provided by DHMH-licensed entities.	Effective July 1, 2003, provisions of §15-840 will be incorporated into the regulations.

MANDATE	MARYLAND	DELAWARE	DISTRICT OF COLUMBIA	NEW JERSEY	NEW YORK	PENNSYLVANIA	VIRGINIA
AIDS	No mandate	No mandate	Coverage required; insurer may not limit coverage or impose a deductible or coinsurance provision related to the care of AIDS or related diseases unless it applies to all covered diseases.	No mandate	No mandate	No mandate	Insurers may not exclude or limit coverage or treatment of HIV infection or AIDS or related complications.
Alcohol/ Substance Abuse	Mandatory Coverage on the same terms as physical illness; minimum 60 days partial hospitalization; 80% coverage for first 5 visits; 65% coverage of 6-30 visits; 50% coverage for visits beyond 30. Lifetime limits same as physical illness.	Mandatory coverage for drug and alcohol dependencies. Terms of the coverage cannot place a greater financial burden on an insured than for covered services of any other illness or disease.	Mandatory Coverage as follows: Minimum yearly inpatient coverage of 28 days, plus 12 days for detoxification; 30 days minimum outpatient visits.	Mandatory coverage for Alcoholism treatment only; must be provided to the same extent as for any other sickness under the contract.	Coverage must be available at the option of the employer and include detoxification of 7 days and 30 days of rehab. Coverage must also include 60 annual outpatient visits.	Mandatory coverage of 7 per admission days inpatient, 30 days non-hospital residential treatment coverage, and 30 days minimum outpatient visits.	Mandatory coverage as follows: Minimum yearly inpatient coverage of 20 days for adults and 25 days for children; 20 days minimum outpatient visits.

MANDATE	MARYLAND	DELAWARE	DISTRICT OF COLUMBIA	NEW JERSEY	NEW YORK	PENNSYLVANIA	VIRGINIA
Cleft Lip and Cleft Palate	Mandatory coverage for orthodontics, oral surgery, and otologic, audiological, and speech/language treatment involved in the management of cleft lip or cleft palate or both.	Managed care organizations must have a policy assuring access to specialty pediatric outpatient centers for treatment of cleft lip and palate as determined to be medically necessary.	No mandate	No mandate	Children must be covered from the moment of birth for the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.	Mandatory coverage for the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.	Coverage required
Clinical Trials	Mandatory coverage for routine costs to an enrollee in a clinical trial for a life-threatening condition or prevention and early detection.	Mandatory coverage for routine patient care costs for covered items and services for enrollees engaging in clinical trials for treatment of life threatening diseases.	No mandate	No mandate	Coverage of items and services related to clinical trials may be required if determined by an external review agent to be medically necessary.	No mandate	Mandatory coverage for patient costs incurred during participation in clinical trials for treatment studies on cancer.

MANDATE	MARYLAND	DELAWARE	DISTRICT OF COLUMBIA	NEW JERSEY	NEW YORK	PENNSYLVANIA	VIRGINIA
Colorectal Cancer Screening	Mandatory coverage for colorectal cancer screening according to the latest guidelines by the American Cancer Society.	Mandatory coverage for colorectal cancer screening for persons 50 years of age or older and those at high risk for colon cancer.	Mandatory coverage for colorectal cancer screening for policyholders residing in the District in accordance with the American Cancer Society guidelines.	Mandatory annual stool examination for all persons 40 years of age or older, mandatory coverage for a colonoscopy every five years for all persons 45 years of age or older. Mandatory colorectal cancer screening at regular intervals for persons age 50 and over and for persons of any age who are considered to be at high risk for colorectal cancer.	No mandate	No mandate	Coverage required for risk groups established by the American College of Gastroenterology.
Contraceptives	Mandatory coverage for any FDA-approved, prescription contraceptive drug or device and related services. Exempts religious organizations.	Mandatory coverage for FDA-approved prescription contraceptive drugs, devices and outpatient contraceptive services; exempts religious employers.	No mandate	No mandate	Mandatory coverage for any FDA-approved, prescription contraceptive drug or device. Exempts religious organizations.	No mandate	If prescription drugs are covered, all FDA-approved, prescription contraceptives must be covered.

MANDATE	MARYLAND	DELAWARE	DISTRICT OF COLUMBIA	NEW JERSEY	NEW YORK	PENNSYLVANIA	VIRGINIA
Dental Procedures	Mandatory coverage for general anesthesia and associated hospital charges for dental care for children aged 7 or younger, the developmentally disabled, and where medically necessary.	No mandate	No mandate	Mandatory coverage for anesthesia and hospitalization for dental procedures for children age five or younger, or the severely disabled.	No mandate	No mandate	Mandatory coverage of anesthesia for dental procedures for children.
Diabetes	Mandatory coverage for all medically necessary diabetes equipment, supplies, and outpatient self-management training and educational services, including medical nutrition therapy.	If prescription drugs are covered, equipment and supplies for the treatment of diabetes must also be covered.	Requires health benefit plans to provide coverage for the equipment, supplies and other outpatient self-management training and education, including medical nutritional therapy.	Mandatory coverage for all medically necessary diabetes equipment, supplies, and outpatient self-management training and educational services, including medical nutrition therapy.	Mandatory coverage for all medically necessary diabetes equipment, supplies, and outpatient self-management training and educational services, including medical nutrition therapy.	Mandatory coverage for all medically necessary diabetes equipment, supplies, and outpatient self-management training and educational services, including medical nutrition therapy.	Coverage required for equipment, supplies and self-management training.

MANDATE	MARYLAND	DELAWARE	DISTRICT OF COLUMBIA	NEW JERSEY	NEW YORK	PENNSYLVANIA	VIRGINIA
Drugs and supplies	Mandatory coverage of blood products and low protein modified medical food products. Mandatory coverage of hearing aids for children up to $1,400 per hearing aid for each ear every 36 months. Policies may not exclude coverage of a drug for an off-label use	If prescription drugs are covered, FDA-approved drugs to treat a covered chronic, disabling, or life-threatening illness must also be covered.	Mandatory coverage for hormone replacement therapy that is prescribed or ordered for treating symptoms and conditions of menopause	Mandatory coverage for food for inherited metabolic diseases and for specialized non-standard infant formulas, for infants with a multiple food protein intolerance.	Mandatory coverage for medically necessary enteral formulas for treatment of certain gastrointestinal and metabolic disorders, and food allergies which may result in malnourishment. Mandatory coverage for off-label use of drugs in the treatment of cancer.	Mandatory coverage for the cost of medically necessary nutritional supplements and formulas in the treatment of phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria.	Mandatory coverage of off-label cancer drugs and excess dosages of drugs to relieve cancer pain.
Emergency Treatment	Mandatory coverage for out-of-network trauma care. Pre-authorization cannot be required before enrollees use the 911 emergency system.	Mandatory coverage for emergency care services performed by non-network providers at an agreed-upon or negotiated rate no less than the rate paid to network providers; the non-network provider may not balance bill the insured.	No mandate	No mandate	Mandatory coverage of emergency room treatment using the prudent layperson standard.	Mandatory coverage of emergency care when medically necessary.	HMOs must provide access to and coverage of emergency medical care.

MANDATE	MARYLAND	DELAWARE	DISTRICT OF COLUMBIA	NEW JERSEY	NEW YORK	PENNSYLVANIA	VIRGINIA
Fertility Treatment	If pregnancy is covered, all outpatient procedures associated with in vitro fertilization must be covered. Exempts religious organizations.	No mandate	No mandate	If pregnancy is covered, infertility coverage diagnosis and treatment must also be covered. Exempts religious organizations and groups with fewer than 50.	Mandatory coverage of diagnosis and treatment of diseases and conditions resulting in infertility; mandatory coverage for FDA-approved drugs used in the diagnosis and treatment of infertility. The mandate does not include coverage for in vitro fertilization, gamete GIFT, ZIFT or reversal of elective sterilization; .	No mandate	No mandate
Hemophilia	No mandate	No mandate	No mandate	Coverage mandated for infusion equipment for hemophilia home treatment.	No mandate	No mandate	Coverage required for the treatment of hemophilia and other congenital bleeding disorders; must include home treatment coverage.

MANDATE	MARYLAND	DELAWARE	DISTRICT OF COLUMBIA	NEW JERSEY	NEW YORK	PENNSYLVANIA	VIRGINIA
Home Health Care	Mandatory home visit coverage for a patient who receives less than 48 hours of inpatient hospitalization following a mastectomy or the surgical removal of a testicle. Mandatory home health care coverage for enrollees who would have otherwise required institutionalization up to 40 visits per year for up to 4 hours per visit.	No mandate	No mandate	Mandatory coverage of up to 60 visits per year if inpatient hospitalization or nursing home care covered.	Mandatory coverage of up to 40 home health care visits per year.	Required coverage for a medically necessary home health care visit within 48 hours after a mastectomy. Mandatory coverage for one home health care visit within 48 hours after discharge for childbirth when discharge occurs prior to 48-96 guidelines.	No mandate
Hospice	Employer must have option to cover.	No mandate	No mandate	No mandate	Employer must have option to cover.	No mandate	Coverage mandatory for hospice services including psychological , psychosocial, and other health services.

MANDATE	MARYLAND	DELAWARE	DISTRICT OF COLUMBIA	NEW JERSEY	NEW YORK	PENNSYLVANIA	VIRGINIA
Mammography Screening	Required coverage for a baseline mammogram for women age 35 to 39, every 2 years for women 40 to 49; and annually for women 50 or older. No deductible can be applied to the coverage.	Mandatory coverage for one mammogram for women age 35 or older, every 1 to 2 years for women age 40 to 50, every year for women age 50 and over and for any woman who is at high risk for breast cancer.	Mandated baseline and annual mammogram for women. Coverage may not be subject to an annual or coinsurance deductible.	Mandatory coverage for one baseline mammogram examination for women who are at least 35 but less than 40 years of age; and one every year for women age 40 and over.	Coverage required for a mammogram at any age for those at high risk for breast cancer, a single baseline mammogram for those age 35-39and annually for those age 40 and older.	Required coverage for all costs associated with a mammogram every year for women age 40 or older or when medically necessary.	Coverage required includes one mammogram for women ages 35-39, one every other year for those 40-49, and one annually for women 50 and older.
Mastectomy	Mandatory home visit coverage for a patient who receives less than 48 hours of inpatient hospitalization following a mastectomy.	No mandate	No mandate	If mastectomy is covered, post surgical hospital stay of 72 hours must be covered.	Post surgical hospital stay must be covered for mastectomy, lymph node dissection or a lumpectomy for the treatment of breast cancer if the procedures are covered under the plan.	If mastectomy is covered, post surgical hospital stay must be covered.	If mastectomy is covered, post surgical hospital stay of 48 hours must be covered. Plan must cover treatment for physical complications related to a mastectomy.
Maternity Care	If pregnancy covered, hospitalization for childbirth and postpartum stay of 48 to 96 hours must also be covered.	Maternity coverage is not required. If it is covered, post delivery stay must meet federal standards. Services by a licensed certified nurse midwife must be covered.	Plans that provide maternity coverage must cover inpatient postpartum stay of a minimum of 48 hours after a vaginal delivery, and 96 hours after a Cesarean delivery.	Maternity coverage not required, but must be an employer option. If it is covered, post delivery stay must be covered for 48-96 hours.	Maternity coverage is required including the services of a licensed midwife , post delivery stay must be covered for 48-96 hours.	If maternity care is covered, post delivery inpatient care must be covered for 48-96 hours. Must also cover services by a licensed certified nurse midwife.	Maternity coverage not required except in the case of rape or incest, but must be an employer option. If it is covered, post delivery stay must be covered for 48-96 hours.

MANDATE	MARYLAND	DELAWARE	DISTRICT OF COLUMBIA	NEW JERSEY	NEW YORK	PENNSYLVANIA	VIRGINIA
Mental Health Treatment	Mandatory coverage on the same terms as physical illness; minimum 60 days partial hospitalization; 80% coverage for first 5 visits; 65% coverage of 6-30 visits; 50% coverage for visits beyond 30. Lifetime limits same as physical illness.	Mandatory coverage for serious mental illnesses. Terms of the coverage cannot place a greater financial burden on an insured than for covered services of any other illness or disease.	Mandatory coverage of 45 days inpatient. Outpatient coverage must be at least 75% for the first 40 visits during the year; 60% after that. Lifetime maximum of the greater of $80,000 or 1/3 the lifetime max for physical illness.	Mandatory coverage for biologically based mental illness at the same level as physical illness, including inpatient, outpatient, and lifetime maximums.	Coverage must be available at the option of the employer and include 30 days inpatient and minimum annual outpatient coverage of $700.	Mandatory coverage of 30 days inpatient coverage and 60 days minimum outpatient visits. Lifetime maximum cannot be less than lifetime coverage for physical illness.	Minimum yearly inpatient coverage of 20 days for adults and 25 days for children; 20 days minimum outpatient visits. Lifetime maximum cannot be more than that for physical illness; coinsurance cannot exceed 50% for outpatient visits more than five.
Nursing Home	Employer must have option to cover for Alzheimer's patients.	No mandate	No mandate	No mandate	Employer must have to option to cover.	No mandate	No mandate
Obesity	Mandatory coverage for the surgical treatment of morbid obesity to the same extent as for other medically necessary surgical procedures for patients with a specified body mass index in conjunction with obesity-related illnesses.	No mandate	No mandate	No mandate	No mandate	No mandate	Morbid obesity coverage for those 100lbs over their recommended weight, or with a specified body mass index in conjunction with obesity-related illnesses.

MANDATE	MARYLAND	DELAWARE	DISTRICT OF COLUMBIA	NEW JERSEY	NEW YORK	PENNSYLVANIA	VIRGINIA
Other Mandated Conditions	Required coverage for an annual routine chlamydia screening test for women who are sexually active; and women and men who have multiple risk factors.	No mandate	No mandate	Mandatory coverage for Wilm's tumor including bone marrow transplants, and purchase of blood products formulas for inherited metabolic disease.	Mandatory coverage for pre-admission tests performed in hospital facilities prior to scheduled surgery. Mandatory coverage of bone density testing for women at risk for osteoporosis.	No mandate	Mandatory coverage for hysterectomy with a 23 hour post-op stay.
Ovarian Cancer	No mandate	Ovarian cancer screening (CA-125) subsequent to treatment must be covered for enrollees residing or having their principal place of employment in Delaware.	No mandate	No mandate	No mandate	No mandate	No mandate
Pap smears	No mandate	Mandatory annual benefit for pap smears for all females age 18 and over.	Mandatory coverage for pap smear annually and when medically necessary. Coverage may not be subject to an annual deductible or coinsurance.	Coverage required for pap smears for all women 20 years of age or older.	Mandatory coverage of two annual pap smears for women aged 18 and older.	Required coverage for an annual gynecological examination and routine pap smears.	Coverage required for annual pap smears.

MANDATE	MARYLAND	DELAWARE	DISTRICT OF COLUMBIA	NEW JERSEY	NEW YORK	PENNSYLVANIA	VIRGINIA
Prostate Cancer	Mandatory coverage for prostate screening for men who are between 40 and 75 years of age or who are at high risk for prostate cancer.	Mandatory prostate cancer screening for enrollees age 50 or above.	No mandate	Coverage Mandatory for prostate cancer screening for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors.	Mandatory coverage for a prostate cancer screening at any age for men having a prior history of prostate cancer; for men age 40 and over at risk for prostate cancer, and annually for men age 50 and over.	No mandate	Coverage required for annual PSA test for men age 50 and older and those age 40 and older at high risk.
Prosthetics	Mandatory coverage for prosthetic following a mastectomy. Mandatory coverage for artificial limbs and orthopedic braces.	No mandate	No mandate	Mandatory coverage for prosthetic following a mastectomy.	No mandate	Required coverage for breast prosthesis after mastectomy.	Mandatory coverage for medically necessary prostheses related to a mastectomy.
Reconstructive Surgery	Mandatory coverage for reconstructive breast surgery, including all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry.	Mandatory benefits for reconstructive surgery following mastectomies including surgery and reconstruction of the other breast to produce a symmetrical appearance and prostheses.	If mastectomies are covered, reconstructive surgery, including surgery of the healthy breast to produce a symmetrical appearance and prosthetic devices must also be covered.	Reconstructive surgery coverage is required after a mastectomy to restore and achieve symmetry, and the cost of prostheses must also be covered.	Mandatory coverage for breast reconstruction surgery after a mastectomy including reconstruction of the other breast to produce a symmetrical appearance.	If mastectomies are covered, coverage is also required for prosthetic devices and breast reconstruction, including surgery of the healthy breast to achieve symmetry. Coverage may be limited to six years following the date of the mastectomy.	Reconstructive surgery coverage is required for breast surgery.

MANDATE	MARYLAND	DELAWARE	DISTRICT OF COLUMBIA	NEW JERSEY	NEW YORK	PENNSYLVANIA	VIRGINIA
Second Opinion	Mandatory coverage for a second opinion when required by a utilization review program.	No mandate	No mandate	Employer must have option to cover second opinions.	If coverage is provided for in-patient surgical care, a second surgical opinion by a qualified physician on the need for surgery must also be covered. Also, second medical opinion for a positive or negative diagnosis of cancer.	No mandate	No mandate
TMJ	Mandatory coverage for face, neck, and head bone and joint conditions if other skeletal bones and joints are covered.	No mandate	No mandate	No mandate	No mandate	No mandate	Head / neck bone disorders, including face and jaw must be covered.
Well Child Care	Mandatory coverage of immunizations, all age-appropriate screening tests, and physical examinations. No deductible is permitted. Adopted children and grandchildren must also be covered.	Childhood immunizations must be covered to age 18. Mandatory coverage for lead screening tests for children at age 1, with additional tests to age 6 for those at high risk.	Immunizations and blood tests for newborns; unlimited visits to age 12; three annual visits age 12 to 18.	Childhood immunizations and lead screening must be covered. No deductible is permitted.	Mandatory well child coverage to age 19.	Immunizations must be covered.	Immunizations must be covered. Well child care to age 6 must be covered and exempt from deductibles and coinsurance.

MANDATE	MARYLAND	DELAWARE	DISTRICT OF COLUMBIA	NEW JERSEY	NEW YORK	PENNSYLVANIA	VIRGINIA
Wellness	No mandate	No mandate	No mandate	Mandatory comprehensive wellness program including physical exams, immunizations, and lab, x-ray, and other screening procedures.	Mandatory coverage of two annual gynecologic visits for preventive care.	No mandate	No mandate